University of Alberta

An Examination of the Death Education Provided in Canadian Nursing Degree Programs

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the

requirements for the degree of *Master of Nursing*

Faculty of Nursing

Edmonton, Alberta
Spring 2005

0-494-08038-8

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Canada

Dedication

This thesis is dedicated to

My parents, Melvin and Marjorie Goodwin

and my godparents, Mary Ellen and (the late) Elwood Clark.

Abstract

Despite many health system, nursing practice, and nursing education changes, the availability and extent of death education to Canadian nursing students have not been reviewed since 1997. The purpose of this study was to gather information on the instructional methods and death education included in nursing undergraduate degree programs offered across Canada. To obtain this information, a questionnaire was sent to all (N=35) Canadian universities that offer baccalaureate nursing degree programs. Based on a response rate of 82.9% (N=29) four key findings are identified: (a) death education was included in all but one of the participating programs; (b) death education was commonly integrated throughout the curricula; (c) compared to a 1997 study, more time is dedicated to death education; and (d) lack of time in the curriculum and lack of clinical placement positions were the main identified challenges. Recommendation and implications for future nursing research, practice, and education are discussed.

Acknowledgement

My sincere appreciation is extended to my thesis committee:

Dr. Donna Wilson (thesis supervisor) for her wisdom, guidance, and support. The confidence she had in my abilities and the enthusiasm she exhibited was deeply appreciated.

Dr. Lory Laing and Dr. Joanne Profetto-McGrath for their support, commitment, and insightful critique.

Most important of all, I am deeply grateful to my family and friends. Your love and support was invaluable in helping me complete my thesis and Masters degree.

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Chapter 1

An Examination of the Death Education Provided in Canadian Nursing Degree Programs

Providing care to the dying, an enduring responsibility for the nursing profession, has received increased attention and research over the years. Although there is diversity in how specific cultures approach death and dying, it is considered less of a taboo issue and discussed more openly today in general Canadian society as compared to 50 years ago (Wilson et al., 2002). In the 1960s, Cicely Saunders' and Jeanne Quint Benoliel's enlightened approaches to death and dying strongly impacted the goal of patient treatment and the caregiver's personal attitude (Coolican, Stark, Doka & Corr, 1994; Dopson, 1984; Lev, 1986; Oliver, 1999; Quint, 1967).

In the late 1980s, health care specialists across Canada engaged in discussion and debate regarding the recognition and development of palliative care (PC) as a specialty (Calman, 1988; Librach, 1988; Macdonald & Mount, 1988; Ventafridda, 1988). At that time, simply defining PC was problematic (Librach). In recognition of the impact of personal attitudes on interactions with patients and families; nurses are now encouraged to reflect upon and share their own feelings and thoughts regarding death and dying (Hurtig & Stewin, 1990). Instead of aggressive treatment aimed at curing a disease process; the dying person's pain, symptoms, and psycho-emotional state have come to serve as the focus of care (Hockley, 1999; Sherman, Matzo, Panke, Grant & Rhome, 2003).

Today, discussion is focused on exploring the many aspects of providing appropriate end-of-life (EOL) care, and on providing the education required by nurses

and other health care practitioners who care for the dying (Sherman, Matzo, Panke, Grant & Rhome, 2003). The aims, knowledge and skills base, and key content areas of PC have been identified; with PC nursing gaining recognition as a specialty (Esper, Lockart & Murphy, 2002; Hockley, 1999; Wright, 2001). Notably, 'Hospice Palliative Care' was recently added as a Canadian Nurses Association specialty certification program, with the first examination offered in April 2004 (Canadian Nurses Association). However, this level of qualification or knowledge is not a prerequisite for all nurses who care for dying persons. Most nurses can expect to care for dying persons, with nursing students also potentially caring for dying persons either during or after their initial undergraduate nursing education. Thus, death education for nursing students is important.

Despite developments in PC, caring for individuals who are dying remains complex and challenging. Caring for a dying patient has been identified as a source of significant stress for both the nursing student (Timmins & Kaliszer, 2002) and practicing nurse (Vachon, 1998). With an aging population and increased longevity of individuals with chronic illnesses (Baumbusch & Goldenberg, 2000; Wilson et al., 2001) much remains to be done to improve care of the dying.

A nurse may provide EOL care in the home of the dying person, a long-term care facility, or an acute care hospital; even an intensive care unit (Alexander, 1990; Hockley, 1989). Each of these settings carries unique challenges for the nurse (Seidel, 1990). An acute care hospital or intensive care unit may not be conducive to meeting the needs of dying patients (Ciccarello, 2003; Hockley, 1999); these environments are noisy and are crowded with monitors and life-saving equipment, with limited privacy and space. Patients are admitted at all hours of the day and night, and death is normally fought

against. Although acute care hospitals may have specialized PC units, these are used mainly by individuals with terminal cancer (Luddington, Cox, Higginson & Livesley, 2001; Subcommittee of the Senate, 2000). According to the Senate Subcommittee's (2000) final report *Quality End-Of-Life Care: The Right of Every Canadian*, only 5% of dying persons receive specialized palliative care. Despite the fact that hospital environments are not designed to provide care to the dying patient, three quarters of the 220,000 deaths each year in Canada occur in acute care hospitals (Wilson et al., 2001).

Providing EOL care in a home or a long-term care facility also bears challenges. The interdisciplinary support provided by pharmacists, physicians, and social workers (usually present in a hospital and so vital to the nurses' ability to provide effective EOL care) may not be present, or only available during specific time periods.

Several authors believe all nurses must have the knowledge and skills to provide appropriate physical care, as well as meet the psychological needs of the dying person and their family (Copp, 1994; Pimple, Schmidt & Tidwell, 2003; Sherman, Matzo, Panke, Grant & Rhome, 2003). Nurses must also remain sensitive to the diverse cultural and religious practices of their clients and client families (Matzo et al., 2002). When providing care to the dying, nurses often participate in discussions regarding life decisions, such as the withdrawal of active treatment, do-not-resuscitate (DNR) decisions, and advance directives; assisting patients and family members in these difficult choices (Haisfield-Wolfe, 1996). Nurse educators consider end-of-life pain and symptom management, communication, ethical/legal issues, and achieving quality end-of-life care as some of the critical content that must be included in nursing education (Pimple, Schmidt & Tidwell).

Given the many roles of nurses in relation to death and dying, including direct care provision, adequate education of nursing students about death and dying should be a key concern. Educating nursing students about end-of-life care can be a complex and challenging task given the breadth of knowledge nurses must know and the sensitivity that is needed around death and dying. The availability of death education in undergraduate nursing programs in the western world has been investigated periodically (Caty & Downe-Wamboldt, 1983; Coolican, Stark, Doka & Corr, 1994; Dickinson, Sumner & Durand, 1987; Field & Kitson, 1986; Lloyd-Williams & Field, 2002; Thrush, Paulus & Thrush, 1979); however, nearly a decade has passed since the death education offered to nursing students in Canada was last examined (Downe-Wamboldt & Tamlyn, 1997). The following study was designed to answer the question, "What education is currently offered to nursing students about the care of the dying in Canadian entry-level baccalaureate nursing programs?"

Purpose of the Study

The purpose of this study was to explore and describe death education in Canadian undergraduate baccalaureate nursing programs during the 2003/2004 academic year. This study also explored the content and methods used by Canadian nursing schools to address death and dying.

Research Questions

The specific research questions addressed in this study were:

1. What proportion of Canadian undergraduate nursing schools/faculties include education on death and dying in their curriculum?

2. What issues/topics are included as part of the death and dying education

provided?

3. What instructional/teaching and learning strategies are used to provide death and dying education?

4. How do these findings compare with those of the last study by Downe-Wamboldt and Tamlyn (1997), examining the death education provided to Canadian nursing students?

Significance of the Study

Recent Canadian government publications (Romanow Report, 2002; Subcommittee of the Senate, 2000) have focused the attention of both the general public and health care professionals on the current state of EOL care and need for improvement. Previously, in 1999, The Honourable Sharon Carstairs motioned that a Senate Subcommittee of the Standing Senate Committee on Social Affairs, Science and Technology be established to update the 1995 report *Of Life and Death*. That Senate Subcommittee's final report, released in June 2000, was entitled *Quality End-Of-Life Care: The Right of Every Canadian.* Developing a national strategy for EOL care was identified as a priority (Subcommittee of the Senate, 2000). Furthermore, The Senate Subcommittee's sixth recommendation for quality EOL care was to explore "ways to increase multidisciplinary training and education of professionals involved in end-of-life care" (p. 37).

The 17th and 18th recommendations of the Romanow Report (2002) also specifically refers to the "education programs and training of health care providers" (p. 108). Romanow recommended these programs be reviewed, become more integrated, and that a comprehensive plan for addressing issues related to education and training be

developed. Given that the last survey of death education for nursing students was in 1997, a study to gain current information regarding the provision of death education for nursing baccalaureate students across Canada will enable educators and PC/EOL specialists to reflect on the current status of undergraduate nursing death education, and how it is designed to meet the needs of Canadians. Areas for improvement may also be noted.

Improving the death education that nursing students receive could enhance their future effectiveness as preceptors for nursing students. In the past, staff nurses have been expected to preceptor nursing students in the care of dying persons in all clinical settings, although many have not had much formal death education themselves (Lyons, 1988). Enhanced undergraduate death education could also provide the platform for more students to specialize in care of the dying, thus increasing the number of PC/EOL care specialists and PC/EOL educators in Canada.

Most significantly, developments in the education that nursing students receive may help nursing students and new graduates be more competent and comfortable in their abilities to care for the dying, thus supporting The Senate's (2000) statement that "quality EOL care be available to every Canadian who needs it" (p. 3). A survey of nursing student death education would also increase the information available to educators planning post-graduate educational seminars or workshops to enhance the skills and knowledge of practicing nurses.

Chapter 2

Literature Review

A literature review was undertaken to identify and document past research and other relevant information on death education. Although this study sought to examine death education in Canadian nursing programs, studies examining death education in nursing programs in other countries, such as the USA and UK were reviewed. Death education in Canadian medical schools was also examined. The review of these studies increased the researcher's understanding about the scope of death education and also the nature of previous questionnaires used to examine death education.

Overview

The following databases were used to search the literature and identify relevant literature on death education: AMED (1985 to November 2003), CancerLIT (1975 to October 2002), CINAHL (1982 to October Week 5 2003), ERIC (1966 to October 2003), HealthSTAR/Ovid Healthstar (1975 to October 2003), MEDLINE (1966 to October Week 5 2003), and PsycINFO (1985 to October Week 4 2003). Key terms used in the search, with results noted in brackets, included: context based learning (5), curriculum (229565), death (97518), death education (1014), end-of-life (1631), nursing (266265), nursing education (18479), palliative care (18872), problem based learning (4832), questionnaire (12019), survey (16495), terminal (48161), and undergraduate (532).

These terms were variably combined to identify relevant research articles. The number of articles obtained through combinations of terms included: nursing and death education (n=48); nursing, death education, and undergraduate (n=7); nursing, death education, and survey (n=11); nursing education and death (n=106); nursing education,

curriculum, and death education (n=22); nursing education, problem based learning, and curriculum (n=55); nursing education, death, and survey (n=10); nursing education, death, and questionnaire (n=7); nursing education and death education (n=48); nursing education, undergraduate, and end-of-life (n=3); nursing education, undergraduate, and death education (n=4); nursing education, undergraduate, and palliative care (n=14); nursing education, undergraduate, and terminal (n=1). These results were then limited to those written in English and duplicates were removed. All relevant articles that focused on death education were retained, a total of 31 articles.

From these 31 articles, four themes were revealed through content analysis:

1. Previous Surveys of Death Education,
2. The Significance of Including Death Education in Nursing Education,
3. Curriculum Approaches and Clinical Practicum in Death Education, and
4. Challenges Faced by Educators in Providing Death Education.

These themes are discussed below, along with a description of associated literature.

Previous Surveys of Death Education

Of the 31 articles included in the analysis, nine were surveys on death education. Two of these articles examined Canadian nursing education (Caty & Downe-Wamboldt, 1983; Downe-Wamboldt & Tamlyn, 1997), three articles examined USA nursing education (Coolican, Stark, Doka & Corr, 1994; Dickinson, Sumner & Durand, 1987; Thrush, Paulus & Thrush, 1979), and two articles examined UK nursing education (Field & Kitson, 1986; Lloyd-Williams & Field, 2002). Two articles examined death education in Canadian medical schools (Macdonald, Boisvert, Dudgeon & Hagen, 2000; Oneschuk,

Hanson & Bruera, 2000).

Canadian nursing education. Two studies sought information on Canadian death education for nursing students. A descriptive-exploratory study by Downe-Wamboldt and Tamlyn (1997) provides the most recent information about death education provided to Canadian nursing undergraduate students. In part, these researchers mailed a questionnaire to nursing faculties in Canada to request information on teaching and evaluation methods, specific content areas, issues being addressed; as well as the background and expertise of faculty members involved in teaching death and dying. Nursing education findings are summarized below.

Downe-Wamboldt and Tamlyn (1997) obtained data from 27 of the 29 nursing schools that were sent a mail questionnaire. According to Downe-Wamboldt and Tamlyn, death education content was included in all 27 of these Canadian nursing schools. Ninety-three percent of these schools integrated the content on death education throughout the curriculum, rather than providing an elective or required separate course. Only 7% offered a death education course that was considered required. The average amount of time allotted for death education was 24.5 hours of classroom instruction and 36.25 hours of clinical practice. The opportunity for students to work with dying patients was available in more than half (66%) of nursing programs.

The most commonly used teaching strategy was lectures (70%). In addition, case studies, small-group discussions, and audiovisual aids were utilized by 59% of the responding schools. Additional teaching strategies were identified as: self-directed activities (44%), role-playing (30%), clinical experience (19%), and journal writing (4%).

The topic included most often by responding schools was family needs (88%).

Communication, loss/grief, and bereavement were topics included by 82% of these schools. Additional topics commonly included in the death education were: spiritual issues (78%), role of health professionals (78%), pain/symptom control (78%), dying with cancer (74%), ethical issues (70%), death anxiety (63%), cultural diversity (63%), the hospice movement (63%), dying with AIDS (59%), legal issues (56%), and body image (52%). Gender issues (41%) was the least common topic.

Methods for evaluating students' knowledge and attitudes were also reported by Downe-Wamboldt and Tamlyn (1997). Evaluation of the cognitive domain of students was accomplished mainly by tests (74%), followed by papers (67%), clinical practice (63%), and case studies (52%). Discussions (82%) were the most common method used to evaluate the affective domain of students, followed by clinical practice (63%), attitude measurement (26%), and death anxiety measurement (22%).

Nursing faculty members were solely utilized for death education in 89% of the nursing programs, while an interdisciplinary approach to death education was used in 33% of the programs. Areas identified by the schools as priorities for future curriculum planning included: affect/emotional issues (41%), provision of focused clinical experiences (26%), addition or refocusing of theoretical approaches (22%), inclusion of palliative and hospice care (15%), issues of cultural diversity (11%), use of an interdisciplinary approach (4%), and taking a more formalized approach to death education (4%).

An earlier survey of Canadian university nursing schools was also reviewed (Caty & Downe-Wamboldt, 1983). This survey was undertaken in part because there was no information regarding the provision of death education in Canadian nursing programs. In

this study, researchers mailed a questionnaire to all Canadian nursing schools, including those offering a basic degree in nursing (BN), a degree program for registered nurses (post-RN), as well as integrated BN and post-RN programs to investigate how the topic of death and dying was dealt with in their curriculums (Caty & Downe-Wamboldt). The questionnaire consisted of both closed-end and short-answer questions to determine: (a) how many nursing schools included education on death and dying in their curriculum, (b) how education on death and dying was taught, (c) how long this education had been in their curriculum, (d) who taught the death and dying content, (e) what teaching methods and strategies were used, (f) how effective the courses were in terms of student learning, and (g) what areas relating to this content should be added to improve student learning.

Of the 29 nursing schools that received a survey, 28 responses were received (Caty & Downe-Wamboldt, 1983). Of these 28, four respondents stated the topic of death and dying was not included in their school's curriculum, three indicated their school offered an elective course in the area, and two indicated their school offered a required course. The majority of nursing school respondents (68%) also reported that content on death and dying was integrated throughout their curriculums. These representatives believed having the death education integrated throughout the curriculum was the best strategy to utilize, as it reflected the view that death is a normal stage in the life cycle. However, when asked to specify the number of hours given to content on death and dying, almost 33% of the respondents for schools that used the integrated approach could not specify the number of hours devoted to it. This finding led the researchers to suggest that integrated death education content was either not integrated in a systematic manner or difficult to quantify. Caty and Downe-Wamboldt also stated that those schools that

provided content on death and dying by means of an elective or required course that specifically focused on death education devoted more hours to the topic than those schools that integrated the content throughout the curriculum.

American nursing education. Three surveys have also investigated the nature and extent of education in death and dying in American nursing schools (Coolican, Stark, Doka & Corr, 1994; Dickinson, Sumner & Durand, 1987; Thrush, Paulus & Thrush, 1979). In 1992, researchers sent a questionnaire to 650 baccalaureate nursing education programs across the USA (Coolican, Stark, Doka & Corr). The response rate was only 32%, with 99% of responding schools indicating they offered education on death, dying, and bereavement. A separate course on death education was offered by 16% of responding schools. The remainder of the schools either integrated the content throughout the curriculum or offered it in specific clinical areas. No clear statement regarding the amount of time or range of time allotted to death education was provided. Although these school representatives cited a total of 16 different models relating to death, dying, and bereavement; 75% of the schools used the model developed by Elisabeth Kubler-Ross (1969). This model identifies five psychosocial adjustment stages a person may experience after becoming aware they have a terminal illness: denial and isolation, anger, bargaining, depression, and acceptance (Kubler-Ross).

The majority of the respondents (83%) indicated some information regarding organ and tissue donation, and transplantation was included in their programs (Coolican, Stark, Doka & Corr, 1994). Comments by respondents also revealed it was commonly believed that death and dying; particularly feelings, grief, and the impact of death on the nurse, were not dealt with adequately in the programs. Respondents also raised the issue

of faculty members having difficulty dealing with the topic of death and dying. Although one respondent's comment indicated their school's content on death and dying was 'individualized' to help students identify their own feelings regarding death and dying, further explanation and discussion on the comment was not provided.

The status of death education in American nursing schools was also surveyed in 1984 (Dickinson, Sumner & Durand, 1987). A response rate of 84% was achieved from the 396 baccalaureate nursing programs surveyed. Content related to death education was included in the curriculum of 95% of responding schools; only 5% offered no education on this topic. The responding nursing schools had offered death and dying education for an average of 7.25 years. Integrating death and dying education in other courses was the practice in 80% of responding schools, with 15% offering a separate course that was dedicated to death education. The majority of representatives (74%) indicated that instructors with a background in nursing alone were used to teach the content on death education. Theology (8%), sociology (6%), psychology (5%), and philosophy (4%) were additional professional backgrounds of instructors used to teach death and dying. Only 5% of these nursing program representatives reported using a multidisciplinary approach in teaching death and dying. A combination of lecture and discussion format was used by nearly half (47%) of all responding nursing schools, with less commonly used methods of teaching including the lecture format (29%) and the seminar/small group approach (24%).

In 1977, researchers also used a mail survey to examine death education in American nursing schools (Thrush, Paulus & Thrush, 1979). A stratified random sample of 226 nursing schools, including those that offered baccalaureate degrees, associate

degrees, and diplomas were surveyed to determine the extent and nature of death education offered to American nursing students. The overall response rate was 91%, with an 89% response rate from the baccalaureate programs. Results revealed 5.4% of the respondent schools had formal death and dying courses offered as required courses, 11.7% offered elective death and dying courses, and 27.8% offered death and dying courses through departments other than nursing.

Ninety-two percent of the schools surveyed integrated concepts or issues concerning death and dying into a number of courses in their curriculum, generally in a modular form (Thrush, Paulus & Thrush, 1979). The courses containing the modular integration of concepts and issues were: medical-surgical, gerontology, care of the acute and chronically ill, and pediatric nursing. Several fundamental courses also devoted time to death and dying concepts or issues, but these courses were not identified.

Respondents indicated the amount of time devoted to the subject of death and dying, when integrated in modular form in courses, ranged from 2 or 3 hours to 3 weeks. Information regarding the depth and breadth of coverage was not included. An average of three credit hours of formal classroom instruction was devoted to death education in both required and elective courses. According to Thrush, Paulus, and Thrush (1979), 44% of the responding nursing schools that offered required or elective courses on death education relied on faculty from other disciplines to teach their courses on death education. Teachers who were not nurses were used because of the limited number of nursing faculty with extensive formal training in death education. Caring for a terminally-ill person during clinical practice was recognized as an opportunity for nursing students to obtain additional instruction on death and dying, but researchers also did not identify a

specific amount of time for this practice. Yet, nursing students had direct contact with terminally-ill persons in 47% of the schools that offered death education in a separate required and/or elective course and in 69% of the schools that integrated death education throughout their programs. Indirect contact with terminally-ill persons through the use of videotapes, closed circuit television, and/or audiotape presentations occurred in 57% of the required and elective courses reported upon.

Ten of the 11 representatives for schools that offered a required course listed an objective of heightened self-awareness, so as to assist nursing students in managing their own emotions while confronting death and caring for the terminally-ill (Thrush, Paulus & Thrush, 1979). The degree to which this objective was planned and integrated in the program was not determined. The researchers also indicated that the majority of these death education courses had existed for only two or three years

United Kingdom nursing education. Of all nursing education investigations, the most recent study exploring the provision of death education for students in undergraduate nursing degree and diploma programs was undertaken in the United Kingdom (Lloyd-Williams & Field, 2002). A response rate of 40% was reported based on 108 questionnaires sent out. From these 46 responses (19/41 diploma and 27/67 degree courses), the researchers learned that undergraduate degree students received an average of 12.2 hours of death education, with a range of 3 to 42 hours. Diploma students received fewer hours of teaching in death education, with an average of 7.8 hours and a range of 2 to 26 hours. Although some schools offered optional clinical modules/electives in palliative care, only a small number of students could be accommodated. Teaching was mainly theoretical, and provided in the form of lectures and small group tutorials. In 76%

of the degree courses and 82% of the diploma courses the death education knowledge that students received was not formally evaluated.

Previously, Downe-Wamboldt and Tamlyn (1997) obtained a 45% questionnaire response rate when they surveyed 51 United Kingdom nursing schools that offered university-based programs in the late 1990s. Death education was included in 96% of the responding programs, with 96% of these programs integrating the content throughout their curriculum. Separate required courses or elective courses were offered by 33% and 17% of the responding schools respectively. A required workshop was the approach to death education in 22% of the schools. The average number of hours allocated to death education was 44.25 for classroom instruction and 100.0 for clinical practice many teaching strategies were reported. Self-directed activities were the teaching strategy used for death education by 100% of the schools. Lectures were also used as a teaching/learning strategy by 74% of the schools. In addition, 70% used case studies, small-group discussions, and audiovisual aids. Other less common teaching strategies included: role-playing (48%), clinical experience (3%), and journal writing (4%).

The most common content areas listed by these respondent UK nursing schools in their death education were ethical issues and the hospice movement, both of which were included by 83% of the responding schools (Downe-Wamboldt & Tamlyn, 1997). The content areas of family needs, bereavement, loss/grief, communication, symptom control, and cultural diversity were addressed by 78% of the responding schools. The role of the health professional, spiritual issues, death anxiety, and legal issues were content areas listed by 74% of the responding schools. Less common content areas included in their death education were: body image (70%), dying with cancer (65%), dying with AIDS

(65%), and gender issues (52%). The theoretical approach of Elisabeth Kubler-Ross was most often used (57%), followed by Parkes (44%), Worden (22%), and Saunders (13%). Papers were the most likely method used to evaluate student knowledge in the cognitive domain (57%); followed by clinical practice (52%), case studies (48%), and tests (26%). Evaluating the affective domain of student knowledge was done mainly through discussions (74%), followed by observation during clinical practice (52%), attitude measurement (17%), and death anxiety measurement (9%). Although 65% of these nursing schools indicated using an interdisciplinary approach for their death education, the majority of programs (83%) most frequently used nursing faculty members to teach the death and dying content. In addition, school representatives identified the following priority areas for future curriculum planning: affective/emotional issues (43%), the addition or refocusing of theoretical approaches (26%), provision of focused clinical experiences on palliative and hospice care (17%), issues of cultural diversity (9%), as well as the use of a more focused interdisciplinary approach to death education (4%).

The earliest of the three studies was by Field and Kitson (1986) who surveyed 192 UK nursing schools in 1984 to determine the formal teaching of death and dying in both degree and non-degree nursing programs. Sixty-four percent (14/22) of the schools that offered degree courses and 88% (178/202) of the schools that offered non-degree programs participated in the study. The amount of time spent on death and dying education in the degree programs ranged between 4 and 38 hours, with a mean of 13.5 hours. Field and Kitson's exploratory study also revealed that all degree courses included the following topics: attitudes to death and dying, bereavement, communication with dying patient and relatives, social contexts of dying, experience of dying, physical

therapy, and demographic aspects. Small group discussion was the teaching method used in the majority of degree courses (92.86%). Less common teaching methods included lecture (85.71%), film/video and clinical case discussion (57.14%), and role-play (7.14%). Although 50% of the responding schools included additional topics and teaching methods in their death education, beyond what was stated in the questionnaire, the researchers did not provide information on these additional topics or teaching methods. An average of 3.6 teaching methods were reported as in use by these UK nursing schools.

Canadian medical education. The death education provided to Canadian undergraduate medical students has also been examined in two recent surveys (Macdonald, Boisvert, Dudgeon & Hagen, 2000; Oneschuk, Hanson & Bruera, 2000). Both of these surveys highlighted the variability of emphasis placed on death education among Canadian medical schools. The more recent of these, by Oneschuk, Hanson, and Bruera, had an 87.5% response rate when they surveyed all 16 Canadian medical schools during the 1997-1998 academic year. A rotation in palliative medicine was deemed to be an elective in 71.4% of respondent schools and mandatory for 14.3% of respondent schools. For those schools that offered an elective PC rotation, the median percentage of students who participated was only 1%. The researchers also found that the median length of a clinical rotation was 28 days when it was an elective, as compared to 5.5 days when it was mandatory.

Macdonald, Boisvert, Dudgeon, and Hagen (2000) surveyed the same Canadian medical schools to examine the status of death education in 1996-1997 (the previous academic year) and the availability of academic staff positions in palliative care. The

100% response rate to their study revealed that an independent PC course, carrying with it the same status as a course in pharmacology, was offered in only 25% of the schools. The number of hours assigned for designated class lectures and small-group sessions in PC ranged from 2 to 24 hours. Furthermore, 62.5% of the responding schools indicated their medical faculty had increased its PC instruction in the past two years. According to the researchers, the variability in emphasis given to palliative care was related to the availability of academic staff positions in palliative care.

Summary of survey findings. In summary, the death education surveys conducted to date reveal that nursing and medical educators generally recognize the importance of including death education in undergraduate student education, with the vast majority of nursing programs including it to some extent in their curricula. Although both 'integrated' and 'course specific' approaches have been utilized, the majority of nursing schools appear to have chosen to integrate death education throughout their curricula. Integration also appears to have increased in recent years. The researchers reasoned that integration may be due in part to educators striving to have death seen as a natural part of living.

It is also evident from past surveys that it is difficult for school representatives to determine the specific amount of time allotted to death education, especially when an integrated approach is utilized. A more clearly evident finding is that there is great variability among schools regarding the amount of time devoted to education on death and dying. Finding time in an already full curriculum appears to be a key challenge that educators have faced. Past surveys also reveal that educators have a significant amount of autonomy regarding the specific topics explored and teaching methods utilized. A

consequence of this autonomy is that death education may differ considerably between schools, and also among individual students at the same school. In nursing schools this diversity may have been from a lack of nurse educators who were prepared to teach death education.

Also evident through these surveys is the issue that providing death education in a classroom setting does not necessarily mean students will also have direct contact with dying persons. Another issue is that students may care for a dying person during a clinical practicum that is not focused on palliative care. Although a clinical practicum that focuses on death and dying is ideal, these practicums have not been common in the past. Minimal clinical placements for students was a challenge that educators have faced in providing death education.

The Significance of Including Death Education in Nursing Education

Twenty-two articles focused on the significance of including death education in nursing undergraduate education, while highlighting a variety of curriculum approaches, including the use of a clinical practicum (Benoliel, 1988; Biley, 1999; Caty & Tamlyn, 1984; Coolbeth & Sullivan, 1984; Degner & Gow, 1988a; Degner & Gow 1988b; Hainsworth, 1996; Hurtig & Stewin, 1990; Johansson & Lally, 1990-91; Kubler-Ross, 1969; Lockard, 1989; Lyons, 1988; McCorkle, 1988; Mok, Lee & Wong, 2002; Morgan, 1988; Pimple, Schmidt & Tidwell, 2003; Quint, 1967; Rideout et al., 2002; Sherman, Matzo, Panke, Grant & Rhome, 2003; Stoller, 1980; Yeaworth, Kapp & Winget, 1974). Three of these discussed the problem-based learning (PBL)/context-based learning (CBL) approach (Alexander, McDaniel, Baldwin & Money, 2002; Biley, 1999; Rideout et al., 2002), and one study examined the use of the PBL/CBL approach in providing death

education to post-RN nursing degree students (Mok, Lee & Wong, 2002).

As indicated by both Lockard (1989) and Lyons (1988), every time a health care professional or health care student interacts with a dying patient they face their own mortality and this constant identification can lead to anxiety. A caregiver inevitably links images of the patient with his or her own inner experience and feelings about death (Hainsworth, 1996). If not educated to cope with the realities of death, the nurse may exhibit defensive behaviors such as indifference, hostility, or detachment towards persons who are terminally ill or dying (Hurtig & Stewin, 1990; Yeaworth, Kapp & Winget, 1974).

Quint (1967) felt that developing personal awareness early in a nurse's professional life was crucial because this awareness may have a significant impact on their nursing practice. Kubler-Ross (1969) also declared that caregivers relate to the dying as a result of the extent to which they have come to terms with their own personal conception of death. Other authors have identified that death education provides the caregiver the opportunity to work through personal anxieties of death and dying, ensuring the caregiver is able to engage in the process of helping the dying person (Yeaworth, Kapp & Winget, 1974).

These articles support the inclusion of death education in nursing curricula, which means the quality and amount of time that it receives must be critically examined. Lockard (1989) stated that death education requires time because to provide adequate information, one must be able to engage in discussion and allow for closure. As spending too little time on the issue may increase student anxiety (Lockard), the process cannot be rushed. Having time for personal reflection, as well as the opportunity to be with and talk

to patients during emotional and sensitive times, have been recognized as crucial elements in learning how to care for the dying (Degner & Gow, 1988b; McCorkle, 1988; Pimple, Schmidt & Tidwell, 2003; Sherman, Matzo, Panke, Grant & Rhome, 2003).

Important shifts in attitudes about death and dying can be realized through education (Caty & Tamlyn, 1984; Yeaworth, Kapp & Winget, 1974). Coolbeth and Sullivan (1984) found that a significant change in student attitude was due to academic exposure, rather than personal experience with death and/or dying individuals, or the interaction of both personal experience and academic exposure.

It is tempting to argue that coping with death and caring for the dying is difficult for everyone and that more experience, which comes with professional practice, would make the experience less difficult. However, some studies have highlighted that neither the accumulation of nursing experience nor personal exposure increase the nurse's ability to cope with death (Coolbeth & Sullivan, 1984; Hurtig & Stewin, 1990; Stoller, 1980). For instance, Stoller found that uneasiness associated with interacting with dying patients was higher among nurses with more experience. In addition, age and experience were found to contribute separately to the nurse's experience, challenging the belief that as a nurse ages their comfort level in caring for the dying increases (Stoller).

Curriculum Approaches and Clinical Practicum in Death Education

As indicated earlier, through reports of surveys of death education, the time dedicated to and curriculum approaches utilized for death education have varied a great deal. This variance is also apparent among nursing schools in a specific country in a given year. This variance, as well as the desire to improve nursing death education, has driven researchers to examine curriculum approaches.

Degner and Gow's (1988a) critical review of 15 evaluations of death education raised issues whenever undergraduate nursing programs integrate death education into their general curriculum rather than consolidate the content in a specific course. These and other researchers have stated the actual amount of time given to death education in the integrated approach is quite limited and, in fact, significantly less than when a separate course is utilized (Caty & Downe-Wamboldt, 1983; Degner & Gow, 1988a). Integrated programs also had great variety in their clinical programs, which increases the variability in student exposure to dying persons.

Degner and Gow (1988a) found most nursing schools with integrated approaches to death education did not have a systematic assignment of students to care for dying patients. In a subsequent study, these same researchers evaluated the effectiveness of both an integrated approach and a required course that included planned clinical practice (Degner & Gow, 1988b). A required course on death and dying made these graduates much more comfortable in providing care for the dying, leading Degner and Gow (1988b) to recommend the inclusion of a supervised clinical practice in death education for nursing students. A clinical experience has also been shown to shape student attitudes and ideas (Benoliel, 1988). However, researchers have found that not every student gains experience in caring for a dying person as part of a clinical practicum (Degner & Gow, 1988b; Pimple, Schmidt & Tidwell, 2003). Johansson and Lally (1990-91) argued that not having clinical experience accompany lectures on death and dying might actually increase the death anxiety of some students.

In summary, although integrated education may recognize death as a normal experience in the lifespan and that death education was a continuing process, it also

produced great variability in the amount and depth of the topic's exploration. This variability was found to be partly due to the personal comfort level and experience held by faculty members in dealing with death and dying (Coolican, Stark, Doka & Corr, 1994; Degner & Gow, 1988a). It is also important to reflect upon Dickinson, Sumner, and Durand's (1987) statement that integrating death education throughout the entire curriculum could signify that educators attribute low priority to this content. Coolican, Stark, Doka, and Corr stated that by not giving death education the status of a separate course could mean educators do not consider the issue seriously. Lockard (1989) also highlighted the significance of offering death education as an elective course rather than a required course. Having a death education course deemed an elective could give the impression that death education was not very important (Lockard). In addition, Lockard asserted those students most anxious about caring for the dying would simply not enroll in a death education course when not required to do so.

Although courses specifically designed to cover death and dying included similar teaching-learning strategies as those used in the integrated approach, the stand-alone courses included more personalized strategies such as journaling, role-playing, and sensitivity exercises (Morgan, 1988; Pimple, Schmidt & Tidwell, 2003). These courses were also organized around specified objectives over a specified time frame.

Integrating death education content throughout the program is the opposite to what Quint (1967) proposed as the best method to deal with the topic of death and dying in her landmark research on the nurse and the dying patient. Quint recommended that the education on death and dying should use a systematic approach, where students are given the opportunity to explore their personal attitudes towards death and dying, and then are

provided with a supportive clinical experience.

Utilization of the PBL/CBL approach. As mentioned earlier, nurse educators often revise their curricula and instruction methods to best prepare students for contemporary nursing practice. The problem-based learning (PBL) or content-based learning (CBL) approach is becoming increasingly common in nursing education (Alexander, McDaniel, Baldwin & Money, 2002; Biley, 1999). Critical thinking, communication skills, participation in teamwork, autonomy, self-directed learning, and skills in decision-making are characteristics the PBL/CBL approach emphasizes and aims to strengthen (Alexander, McDaniel, Baldwin & Money).

Some studies have found PBL/CBL to be an effective approach for educating nurses (Alexander, McDaniel, Baldwin & Money, 2002; Rideout et al., 2002). For example, a study comparing PBL/CBL and conventional curricula in nursing education found PBL/CBL students functioned at a higher level in the areas of communication and self-directed learning (Rideout et al.). In addition, students in programs with PBL/CBL curricula were more satisfied with their educational experience than their counterparts (Rideout et al.). Biley (1999), however, found students in PBL/CBL programs felt increased levels of tension throughout their program and required careful introduction to the PBL/CBL concept and frequent reinforcement of the aims of their program. Biley's study highlighted the fact that the PBL/CBL approach is not without challenges.

Mok, Lee, and Wong (2002) investigated nursing students' perspectives regarding the use of the PBL/CBL approach to address death education. Students involved in this study were enrolled in a post-RN nursing degree program at a Hong Kong university. The integrated approach of incorporating death education into pre-existing curricula was the

usual strategy for addressing the topic of death education. The focus of teaching was primarily on acquiring knowledge rather than exploring attitudes and developing skills. These researchers asked student participants to document their perception of learning using the PBL/CBL approach in journals during the time they were enrolled in the course 'Applied Psychology'. Ninety-six sets of journals were collected and analyzed. These journals revealed the use of the PBL/CBL strategy for addressing the content on death and dying was well received by the students. It enabled them to reflect on their own attitudes towards death, and understandings of the emotional aspects of death and dying. Acquiring increased self-awareness, positive attitudes towards death, and providing culturally-sensitive care were the three themes derived from the findings, all of which related to nurse attitudes and caring behaviors towards dying persons. With this opportunity to reflect on their own attitudes towards death, and the emotional aspects of death and dying, students were highly satisfied with the PBL/CBL approach. Tutorials served as a safe environment for discussion and sharing of information. Students sought information on the issue independently, even interviewing experts and patients on their experiences (Mok, Lee & Wong). However, because death is considered a 'taboo topic' in the Chinese culture and students did not previously have the opportunity to reflect on their own attitudes towards death and the emotional aspects of dying, perhaps the responses to use of the PBL/CBL strategy were especially favorable. The fact that students in this study were in the post-RN degree program, with previous clinical experiences on which to reflect may have also served to raise satisfaction with the PBL/CBL approach.

Challenges Faced by Educators in Providing Death Education

As discussed previously, the most recent examination of death education at a nursing undergraduate level was completed in 2002, with researchers using a questionnaire to examine the provision of death and dying education in UK nursing schools (Lloyd-Williams & Field, 2002). Although most of the U.K. survey respondents (82%) felt death education should be a core component of entry-level nursing education, a smaller amount of time allotted to the subject was found when compared to the results of an earlier study by Field and Kitson (1986). More specifically, Field and Kitson found an average of 13.5 hours were spent on death education, whereas in the 2002 study, Lloyd-Williams and Field found an average of only 7.8 hours. Respondents to the latter survey identified the following issues faced by modern-day educators when trying to provide death education: finding qualified and experienced faculty to teach death and dying, a lack of clinical placements to accommodate students, and a full curricula (Lloyd-Williams & Field).

In 1989, Lockard contended that with so much new theoretical content accumulating on preventive and curative aspects within nursing practice, nurse educators were giving death education a low priority in their curriculum. This may explain why a small number of respondents (10%) of the 2002 study examining death education in UK nursing schools believed that education on care of the dying should not be a core component of undergraduate nursing programs (Lloyd-Williams & Field, 2002). These respondents also stated they were unsure whether the majority of their students at the undergraduate nursing education level were 'ready' for death education (Lloyd-Williams & Field).

A lack of formal assessment of PC knowledge was also highlighted in Lloyd-Williams and Field's (2002) study. This study found only 24% of survey respondents stated that knowledge of providing care to the dying was formally assessed in their nursing degree courses (Lloyd-Williams & Field). Respondents also criticized the emphasis on cancer-related death education, believing that death education should be broadened to include the needs of non-cancer patients as well. The lack of trained and experienced PC/EOL educators, coupled with the scarcity of clinical placements made the provision of theoretical and clinical death education a challenge. Study respondents acknowledged that these factors had to be addressed to improve and increase death education for nursing students (Lloyd-Williams & Field).

Although educators recognize that a multidisciplinary approach to teaching and learning about the provision of care for the dying is desirable, as it may be the ideal way to encourage health professionals to work together to meet the needs of dying patients and their families, this method was found to be rarely utilized (Downe-Wamboldt & Tamlyn 1997; Dickinson, Sumner & Durand, 1987; Caty & Downe-Wamboldt, 1983). According to Morgan (1988), a multidisciplinary approach is much more likely to be utilized if death education is provided in a single course described specifically as being multidisciplinary and not affiliated directly with the university's nursing department.

Death education content of nursing textbooks. Recognizing that textbooks provide an important source of knowledge for nursing undergraduate students, researchers in a 1999 study selected 50 current texts used most frequently in nursing schools and evaluated their death education content (Ferrell, Virani, Grant & Borneman, 1999). The subject areas (and number of texts) included in this analysis were: ethics/legal issues (5),

medical-surgical (5), community/home health issues (4), critical care (4), pharmacology (4), nursing review (4), assessment/diagnosis (3), fundamentals (3), gerontology (3), pediatrics (3), psychiatric (3), communication (2), emergency (2), oncology (2), patient education (2), and AIDS/HIV (1).

'Death' and 'bereavement', two significant aspects of death education, were two key aspects of PC/EOL care that the researchers also examined in depth. They found only 65 of 45,683 pages in the 50 textbooks were devoted to death and only 94 pages devoted to bereavement, a total of 0.14% and 0.21% respectively. As such, the researchers indicated there was minimal content or focus on PC/EOL.

Given that the research indicates schools primarily integrate death education content throughout courses, it is highly unlikely that students are now required to have a specific textbook for death education. Although none of the previously discussed surveys of death education in nursing schools asked participants whether a textbook on death and dying was utilized, it is relevant to contemplate the priority that death education has for both the writers of nursing textbooks and the educators who use them. PBL/CBL, in which students independently seek knowledge sources to support their learning, could have also affected the need for and use of textbooks.

Summary of Literature

This literature review points out that death education has been recognized as a common component in undergraduate nursing education. For nursing students, death education has often consisted of learning about the care of dying persons in addition to their personal exploration of self. Teaching strategies conducive for this learning are thus essential. Although lectures have been commonly used in death education, more

introspective approaches such as journaling and small-group discussions have also been utilized. Minimal content regarding death and dying in nursing textbooks was highlighted.

Death education to date appears to have encompassed knowledge about caring for dying persons and their family, both physically and emotionally, as well as the role of the nurse in multidisciplinary environments. Topics such as pain/symptom control, communication, loss/grief, and bereavement, and the needs of the family were commonly included in nursing curricula. Spiritual, legal, and ethical issues were also explored.

Despite the positive characteristics of each specific curriculum approach, limitations and challenges for each were also highlighted. Although educators recognized the importance of exposing students to dying persons, providing students with this opportunity was not always possible. Regardless of the belief by some that a stand-alone course focused on death education increases the likelihood that students will have a clinical practicum that focuses on death education, the majority of nursing schools surveyed integrated their death education throughout their curricula. Difficulty in quantifying the actual amount of time devoted to death education when the content was integrated throughout the curricula was also noted.

Chapter 3

Method

Design and Rationale

All previous studies that investigated the availability and description of death education provided to nursing and medical undergraduate students in Canada, USA, and UK used mail surveys to obtain their data (Caty & Downe-Wamboldt, 1983; Dickinson, Sumner & Durand, 1987; Downe-Wamboldt & Tamlyn, 1997; Field, 1984; Field & Kitson, 1986; Lloyd-Williams & Field, 2002; Macdonald, Boisvert, Dudgeon & Hagen, 2000; Oneschuk, Hanson & Bruera, 2000; Smith, 1994). In keeping with past research and in consideration of the best method to answer this study's research questions, a descriptive/comparative design was used. This research design supported a broad inquiry into the topic of death education for nursing undergraduate students in Canada.

Based on a decision to include the entire population of university-based nursing schools that offer baccalaureate nursing degree education across Canada, a mail survey was used because it was an inexpensive and time-efficient strategy for data collection. Mailing the survey was also less expensive than completing the survey through interviewing each representative over the telephone or in person. A mailed copy of the questionnaire (Appendix A), as well as the information letter (Appendix B) introducing and explaining the study, was also thought to be a superior method of collecting data, as it would enable the respondents to include the knowledge of additional faculty members in their responses, and complete the questionnaire at their own time and place. Respondents were assured that participation in this study was voluntary, as was responding to each question. No reward, financial or otherwise was offered to

respondents, although respondents were told they would receive a summary of findings.

Respondents had approximately four weeks to complete and return the questionnaire. Four weeks was thought to be an adequate time for the questionnaire to be completed, yet not an excessive length of time where it could be put aside and forgotten. A reminder letter (Appendix C) and repeat questionnaire was to be mailed to those schools that had not returned the completed questionnaire three weeks after the original mailing. As indicated above, representatives were promised that an executive summary report of study findings and conclusions would be sent to each school/faculty that responded to the survey. Respondents would also receive notice of the thesis title, investigator name, and university affiliation so they can access the entire thesis if desired.

Using a survey design, with the questionnaire results reported anonymously, including all Canadian university nursing schools in the study, and a promise of providing respondents a summary of the study findings were factors designed to increase the return rate of questionnaires. The response rate of the 1997 and 1983 studies that utilized questionnaires to attain information on death education in Canadian nursing programs was 93% and 97% respectively (Downe-Wamboldt & Tamlyn, 1997; Caty & Downe-Wamboldt, 1983).

Target Population

The entire population of Canadian universities that offer undergraduate baccalaureate (generic) nursing programs were considered important to include in this study (Appendix D). A total of 35 Canadian universities were thus targeted for this study. The Canadian Association of Schools of Nursing (CASN) website (http://www.casn.ca) was used to formulate a list of universities and obtain the names of appropriate contact

persons. The CASN is the national voice for nursing education, as it represents nursing programs in Canada, and is the accrediting agency for baccalaureate nursing programs in Canada. The website of each university was also examined to cross reference information regarding the specific undergraduate nursing program(s) offered, the name and faculty position of the appropriate contact person, and mailing address.

As it is increasingly common for multiple sites to collaborate in providing undergraduate baccalaureate nursing degree programs (Wood, 2003), information regarding collaborative baccalaureate partnerships among universities and colleges was also obtained from the Nursing Education Programs and Collaborative Partnerships databases of the CASN and email communications with the Director of Data and Communications, K. Whittle (personal communication, October 28, 2003 and November 17, 2003). Given the same generic curriculum is followed in each collaborative site, only the main or 'parent' school was included in this study (Appendix E).

Schools that offered only post-RN nursing degree programs were excluded from this study because the focus of this study was on introductory nurse education, not secondary or continuing nurse education. For schools that offered both undergraduate baccalaureate nursing degree and the post-RN degree, the researcher specified in the information letter that responses to the survey were to refer only to the undergraduate baccalaureate nursing degree program.

Data Collection Instrument Development

An examination of the information gained through previous studies (Caty & Downe-Wamboldt, 1983; Dickinson, Sumner & Durand, 1987; Downe-Wamboldt & Tamlyn, 1997; Field, 1984; Field & Kitson, 1986; Lloyd-Williams & Field, 2002;

Macdonald, Boisvert, Dudgeon & Hagen, 2000; Smith, 1994), along with an examination of the medical education survey questionnaire used by Oneschuk, Hanson, and Bruera (2000), and selected literature on death education and curriculum development guided the number and type of questions in the questionnaire. Five experts in survey design, palliative care, and education were involved in a pilot test of the questionnaire. Appropriate changes were made, based on their input, regarding the content and format of the questionnaire. The introductory letter, questionnaire, and reminder letter had a Flesch-Kincaid grade reading level of 11.3, 7.4, and 12.0. It was, therefore, not anticipated that school/faculty representatives would have any difficulty completing the survey.

Each school/faculty received a numbered questionnaire. The questionnaire was double-sided to reduce mailing costs. The questions were primarily close-ended, fixed alternative, and the order that they appeared was standardized, as recommended by Brink and Wood (1998). The questionnaire was composed of 22 questions. Background information was also collected. For some questions, space was provided for the respondent to report or explain their answers. Although most of the information sought in this questionnaire was factual (questions #1 - 11), respondents were also asked to share their opinion on six death education issues (questions #12 - 17). One additional open-ended question (#18), "What additional information on death education would you like to share?" was included at the end of the survey. This question was added to provide respondents with an opportunity to express their personal or other thoughts on the topic of death education.

French translation. All documents were translated into French and then back

translated for those four schools that function solely or primarily in that language. A bilingual PhD university faculty member and a translator from a business in Winnipeg, Manitoba who offered translation services translated the research study documents. Back-translation of the questionnaire was completed at no cost, by a personal acquaintance of the investigator. An additional personal acquaintance translated the long answer responses from French to English.

Research Procedure

Following research ethics approval in January 2004 (Appendix F), the questionnaire, the cover letter introducing the study, and a self-addressed stamped envelope for the survey return was mailed in one envelope to the Dean, Director, or Chairperson at each of the 35 schools/faculties. To ensure that the best person or persons would actually complete the questionnaire, these individuals were asked to pass the questionnaire to the individual(s) they felt was most knowledgeable about the death education offered in their program.

The survey packages were mailed to the 31 potential respondents who operated in English on February 28, 2004 with a 4 week return date. A reminder letter and repeat questionnaire were mailed on March 22, 2004 to the 22 school representatives who had not returned their survey by the requested date. No further reminders were used to solicit questionnaires.

Due to the time it took to translate and back translate the documents into French, the questionnaire and introductory letter were not mailed to the four schools that functioned mainly or solely in French until April 2, 2004. A reminder letter and repeat questionnaire was mailed to all four of these schools on April 16, 2004, as no completed

questionnaires had been returned by that date. Members of this sub-group who had not returned their survey by June 28, 2004 were not contacted again.

Although schools were informed in the introductory letter that the deadline dates to receive the completed questionnaires were the end of March and the end of April for the English and French schools, respectively, questionnaires were accepted until June 28, 2004. Since June 28, 2004 was the meeting date for the researcher and thesis supervisor to discuss and complete data entry, it seemed sensible to extend the deadline and to accept questionnaires until that date. The last questionnaire was received on June 25, 2004.

Ethical Considerations

Protecting the identity of each respondent and school/university, voluntary participation, and maintaining confidentiality of data were the three major ethical considerations for this study. As such, they were key factors in obtaining ethical clearance and in the data collection procedure of choice. Anonymity was planned and assured by randomly assigning a unique number to each questionnaire. Each number was matched to a distinct school. A master sheet with each school's identity and code number was kept in a secured drawer in the thesis supervisor's office, completely separate from the data. Only the researcher and the thesis supervisor had access to this master sheet. Anonymity of respondents was maintained throughout French-English translation since the questionnaires were identified by code only and none of the translators had access to the master list of schools or school representatives. Any publications that result from this research will continue to provide anonymity, by not making any reference to the study participants or schools individually.

Data from this study will be kept for five years in a locked cabinet in the thesis supervisor's office and then destroyed in keeping with University of Alberta ethics guidelines. Assuring anonymity of respondents was also meant to reassure each participating school that the purpose of this study was to gather information regarding the extent and manner of death education for undergraduate nursing students in Canada, rather than to evaluate or rank university programs.

Researcher and supervisor contact information was included on the information letter for those respondents with questions or concerns. The Health Research Ethics Board (Panel B) at the University of Alberta served as an additional contact for study participants. This Board's contact information was also provided on the information letter.

Data Analysis

Given the largely quantitative nature of the data, data analysis was primarily conducted using the Statistical Package for the Social Sciences (SPSS) version 12.0 for Windows computer software package. The investigator coded and completed all data entry. Several checks to ensure accuracy of data coding and entry were completed by both the investigator and thesis supervisor. The thesis supervisor also randomly reviewed several of the returned questionnaires to validate data entry.

Data analysis included calculating an overall response rate, as well as a response rate for each question in the questionnaire. Frequency, percentage, and mode were the descriptive statistics used to analyze the following questions: 1, 2, 3, 4, 5, 6, 7, 8, 9 (a) and (b), 10, 12, 13, 14, 15, 16, and 17. Questions 5 and 9 were further analyzed to include the range of responses and the average number of hours. Frequency and percentage were

calculated for question 10. Mode and frequency were also used to summarize responses from question 11. Basic descriptive statistics (frequencies, percentages, means, medians, and modes), including standard deviations and ranges, allowed the data to be summarized and most research questions to be answered. Thematic analysis was used to analyze the data from the open-ended question at the end of the survey (question 18), as well as all responses to questions that asked for additional voluntary information (2, 5, 6, 7, 12, 13, 14, 15).

The data analysis results are described in the following discussion section. Tables are used to answer the four research questions and summarize questionnaire responses. These tables are titled: 'Size of 2003-2004 Graduating Class' (Table 1), 'Number of Faculty Who Specialize' (Table 2), 'Respondent's Primary Position' (Table 3), 'Curriculum Approach Utilized' (Table 4), 'Description of Separate Course' (Table 5), 'Year Content Addressed' (Table 6), 'Target Hours for Classroom Instruction' (Table 7), 'Issues/Topics Included in the Schools' Death and Dying Education' (Table 8), 'Number of Issues/Topics Included' (Table 9), 'Instruction/Teaching and Learning Strategies Utilized in the Schools' Death and Dying Education' (Table 11), 'Number of Instruction/Learning Strategies Utilized' (Table 12), 'Clinical Practicum Focused on Care of the Dying' (Table 15), 'Time Allotted to Clinical Practicum' (Table 16), 'Methods Used to Evaluate Students' Cognitive Domain' (Table 17), 'Methods Used to Evaluate Students' Affective Domain' (Table 18), and 'Challenges Educators Faced' (Table 19).

In addition to the above central tendency/descriptive statistics, bivariate analysis was undertaken to explore associations among each issue/topic or instruction/learning strategy and the following eight variables: size of the graduating class, presence of

faculty members who specialize in death and dying, the number of these specialist faculty, presence of a center that specializes in death and dying, presence of a clinical practicum, respondents' satisfaction with content, total number of issues/topics covered, and respondents' feeling regarding their students being prepared to care for a dying patient. These specific bivariate analysis were completed because the issues included in death education and the methods utilized in teaching death education were the primary foci of this study. This bivariate analyses thus provided more complete answers to the research questions asked in this study. Associations were determined using chi-square or *t* test analysis, with a significance level of $p<.05$. The chi-square test was used to test the significance of differences in proportions and the *t* test was used to test the differences between means. These findings are also described in the discussion section of this report. The tables that report the findings of this bivariate analysis have been titled as followed: 'Exploring Issues/Topics Included in Death and Dying Education' (Table 10) and 'Exploring Instruction/Learning Strategies Utililized in Death and Dying Education' (Table 13).

To answer research study question 4, one final data analysis procedure was conducted. Because some questions in this study were not identical to those used in the study by Downe-Wamboldt and Tamlyn (1997), only some comparisons were possible. These comparisons include: whether or not death education was included in the curriculum, curriculum approaches to death education, average number of hours allocated to both classroom and clinical instruction, methods used to formally evaluate the death and dying content, teaching methods and strategies utilized, as well as topic/issues included in the death and dying education. No statistical analyses comparing the results

of this study and Downe-Wamboldt and Tamlyn's study were conducted, as the data from Downe-Wamboldt and Tamlyn's study were not obtained for analysis. These comparisons are summarized in the table titled, 'Comparison of Findings from the Present Study and Study Published in 1997 that Examined Death Education' (Table 14).

Limitations

The one major limitation of this study was that data collection depended upon school representatives completing and returning questionnaires. The individuals who completed the questionnaires were expected to be knowledgeable about the topic of death education in their school, with the researcher not in a position to verify the information provided. Having the most appropriate person(s) at each school complete the survey was also beyond the researcher's control.

Respondents were asked to contact the researcher or thesis supervisor to seek clarification of any question(s) if the meanings were not clear. None of the respondents sought clarification. Limitations inherent in the survey design, such as comfort level of the respondents' environment, including temperature and lighting, mood of the respondents, and the ability to commit adequate time to reflect on the death education provided by the faculty/school may have also been present and beyond the control of the researcher. Furthermore, the total number of questions and design of the questions themselves were inherent limitations. Although the purpose of the questionnaire was to gather information, it could not be so extensive and time consuming that respondents were discouraged from completing it. The fixed alternative design of the questions also posed limitations because the respondents were asked to choose from given alternatives rather than answer in their own words.

Additionally, because of the collaborative nature of nursing programs among some universities and colleges, only 'parent' universities were sent a questionnaire. The university representative(s) who responded to their school's questionnaire was expected to accurately reflect all collaborating schools. The provision and extent of death education content was also not expected to deviate from the planned (parent) curriculum.

Another limitation is that each respondent may interpret their curriculum, and use their personal judgment to priorize death education topics in response to the students' learning needs and resources available to them. Their responses likely represent what is stated in the curriculum for educators to follow. Their survey responses are not likely to account for the discussion/learning about death education/care of the dying that occurs in other areas of the curriculum not designated as 'death education.' In addition, a student may have cared for a dying patient or be involved in an unexpected death during a clinical practicum that was not designated for providing care to the dying. It is highly unlikely that the person(s) completing the questionnaire was aware of all such situations. Although students may gain experience and knowledge through caring for dying persons, this learning may not have come from that part of the curriculum specified as death education. Furthermore, discussions on death and dying between clinical practicum instructors and students are also not likely accounted for. Each respondent was also asked about personal views regarding death education. These views are those of the respondent only, they do not represent the school's position.

Reliability and Validity

Clear wording of all survey questions and ensuring that these questions were representative of the content being investigated were two key aspects used to increase the

validity of this study (Brink & Wood, 1998). Having five experts in survey design, palliative care, and education pilot test the questionnaire improved the instrument's face validity (Brink & Wood, 2001). Feedback from these experts was utilized to ensure the questions were simple, clear, and as specific as possible (Nieswiadomy, 1998). Providing this panel of experts with the survey, and with the purpose and objectives for the study, served to increase content validity (Nieswiadomy). Comparing the content of the survey with available literature was also undertaken to increase content validity. In addition, the questions were designed to permit key data comparisons with the previous survey conducted by Downe-Wamboldt and Tamlyn (1997).

Budget

No external funding was sought for this study. Research expenses included the costs of photocopying the questionnaire and information letter, and mailing costs (Appendix G). The thesis supervisor covered the largest expense, the cost of translating the documents into French.

Chapter 4

Findings

This chapter on findings is divided into seven sections. The first two sections detail the study's response rate and description of respondents. The next four sections describe findings pertaining to the research questions; specifically, the inclusion of death education, issues/topics included, instruction/learning strategies utilized, and comparison to the findings from the 1997 study by Downe-Wamboldt and Tamlyn. The final section describes additional findings from the questionnaire responses.

Response Rate

The entire population of Canadian universities offering undergraduate baccalaureate generic nursing programs was included in this study. Each of the 35 (parent) Canadian Universities received a questionnaire. Of the 35 questionnaires sent, 31 were sent to English-speaking schools and four to French-speaking schools. Nine questionnaires were returned from English-speaking schools after the initial mailing. An additional 16 questionnaires were received after the reminder letter was sent. The return rate from the 31 English-speaking schools was thus 80.6% (25/31). Although none of the French-speaking schools returned the questionnaire after the initial mailing, the response rate increased to 100% (4/4) after the reminder letter was sent. The respondent(s) from one of the French-speaking schools chose to complete the questionnaire in English. In total, of the 35 questionnaires sent, 29 completed questionnaires were returned, providing an overall response rate of 82.9%.

Description of Respondents in the Study

Background information on the respondent schools was obtained through four

questions: The size of the respondents' undergraduate graduating class from the previous university year (2003-2004); availability of faculty members who specialized or focused their practice on death and dying; the existence of a center focusing on death and dying, palliative, and/or end-of-life care at their university or in their province; and the primary position of the person completing the questionnaire. The background information from these questions offers a broad description of both the school as a whole, as well as the individual(s) who responded to the survey, without revealing the identity of the school or the identity of the person(s) completing the survey.

Size of graduating class. The findings from the question on size of the previous year's (2003-2004) graduating class are contained in Table 1. Of the 29 respondents who returned completed questionnaires, six (20.7%) did not answer the question regarding the size of last year's graduating class. Three of these six respondents stated that they were establishing new programs, so there have been no graduates from these programs as of yet. For the 23 respondents, the average size of the graduating class for 2003-2004 was 125 students with a range of 29 to 350 students (SD=102.4, Mdn=99.0). Slightly more than half of the respondents (52.2%) had a graduating class of less than 100 students. Approximately three-quarters (78.3%) of the respondents had 153 or fewer students graduating. Only 13% respondents (5/23) reported a graduating class of 250 or greater.

Table 1

Size of 2003-2004 Graduating Class

Respondents (N=23)

Mean	Mdn	Mode	SD	Min	Max
124.83	99.00	29	102.374	29	350

Note. Multiple modes exist (29, 120, 250). The smallest value is shown.

Faculty who specialize. All 29 respondents completed the question regarding faculty members who specialize in death and dying, palliative care, or end-of-life care. The majority of respondents (65.5%, 19/29) indicated they had one or more faculty who specialized, whereas the remaining 34.5% (10/29) indicated they did not have faculty who specialize in the area. All 19 respondents who indicated that their school programs had faculty members who specialize in death and dying provided information regarding the actual number of such faculty (see Table 2). The number of faculty members who specialize in death and dying ranged from 1 to 6 (*SD*=1.408), with just over half (57.9%) indicating one or two faculty members who specialized (*Mode*=1). The average number of faculty members who specialized at each of these 19 schools was 2.26 (*Mdn*=2).

Table 2

Number of Faculty Who Specialize

Respondents (N=19)

Mean	Mdn	Mode	SD	Min	Max
2.26	2	1	1.408	1	6

Center that specializes. Of the 29 respondents who completed the questionnaire, one did not answer the question on centers that specialize, stating that the phrase 'a center' was unclear. The majority of respondents who answered this question (67.9%, 19/28) stated they had a center that focused on death and dying, palliative care, or end-of-life care either at their university or in their province. The remaining 32.1% of respondents stated they did not have such a center at their university or province.

Respondent's primary position. Table 3 contains a summary of the data from the question on what respondents indicated was their primary position in the school. All respondents answered this question (29/29). Respondents most frequently (65.5%) held an administrative position; instructor/professor was the second most common (58.6%, 17/29) position held. The least likely position indicated by respondents was membership on a curriculum committee, only 13.8% (4/29) indicating this as their primary position.

Table 3

Respondent's Primary Position

	Frequency (N=29)	Percent	Valid Percent
Administration	19	65.5	65.5
Curriculum Committee	4	13.8	13.8
Instructor/Professor	17	58.6	58.6

Note. Does not total 100% because 10 respondents indicated more than one primary position.

Research Question #1 Findings

1. What proportion of Canadian undergraduate nursing schools/faculties include education on death and dying in their curriculum?

All 29 respondents who returned the questionnaire answered this question. Education on death and dying was included in the curriculum of 28/29 (96.6%) schools. The one respondent (3.4%) that indicated education on death and dying was not included in their curriculum stated that a course is currently being developed. Given all but one respondent included education on death and dying in their curriculum no further statistical tests, which would have compared those schools that included education on death and dying with the school that did not include education on death and dying were conducted.

All respondents who indicated their school currently included education on death and dying (N=28) described the curriculum approach utilized (see Table 4). Integrating the content on death education throughout the curriculum was the most common approach (57.1%, 16/28). Utilizing two curriculum approaches simultaneously, such as focusing the content on death and dying in a separate course(s) plus integrating the content throughout the curriculum, was the approach adopted by 28.6% (8/28) of the respondents. Four respondents (14.3%) reported death education was provided in one or more course(s) that focused exclusively on death education.

Table 4

Curriculum Approach Utilized

	Frequency (N=28)	Percent	Valid Percent
Integrated throughout curriculum	16	55.2	57.1
Separate course and integrated throughout curriculum	8	27.6	28.6
Separate course	4	13.8	14.3

For all 12 respondents who indicated their schools included content on death and dying in a separate course(s), 50.0% of these respondents (6/12) indicated this separate course was an elective, while the other 50.0% (6/12) indicated this course(s) was required (see Table 5).

Table 5

Description of Separate Course

	Frequency (N=12)	Percent	Valid Percent
Required	6	20.7	50
Elective	6	20.7	50

More specifically, in the case of the eight respondents who indicated the content on death and dying was both integrated throughout the curriculum and in a separate course, the separate course was considered elective by 50% (4/8) of the respondents. For the other 50% (4/8) of respondents, the separate course was required. Two of the four respondents (50%) who indicated death education was only in a separate course said this course was an elective, while the other 50% (2/4) said it was a required course.

Respondents indicated the specific year(s) when their school's content on death and dying is addressed for students (see Table 6). For the 28 respondents who answered this question, 39.3% (11/28) indicated the content was integrated over the entire four years of the program. The remaining 60.7% (17/28) of respondents had a specific year or number of years in which the content was presented. Ten of these seventeen respondents indicated a single or individual year (35.7%), while the other seven respondents (25%) had the content integrated over two or three years. In most cases (80%), this content was

presented in the 2nd year (40%) or the 3rd year (40%) of the program.

Table 6

Year Content Addressed

	Frequency (N=28)	Percent	Valid Percent
Only in 2nd year	4	13.8	14.3
Only in 3rd year	4	13.8	14.3
Only in 4th year	2	6.9	7.1
Over 2 years	5	17.2	17.9
Over 3 years	2	6.9	7.1
Over all 4 years	11	37.9	39.3

Respondents were asked whether or not there were a target number of hours designated for classroom instruction on death and dying (question #5). Four of the 29 respondents did not answer this question, with only nine respondents (36%) indicating a target number of hours were designated for classroom instruction. This number of hours ranged from 4 to 215, with an average of 47.6 (*SD*=64.8, *Mdn*=39.0), although the majority of respondents (88.9%, 8/9) reported a target of 45 hours or less (see Table 7). One respondent indicated a target of more than 45 hours, which was 215.

Table 7

Target Hours for Classroom Instruction

Respondents (N=9)

Mean	Mdn	Mode	SD	Min	Max
47.56	39.00	39	64.808	4	215

Note. Multiple modes exist (39, 45). The smallest value is shown.

Three of the respondents indicated it was difficult to designate an actual number of hours when the content is integrated throughout the courses or in programs that utilize the PBL/CBL approach. For instance, one respondent at a school utilizing the PBL/CBL approach indicated that it was impossible to provide a specific amount of hours dedicated to content on death and dying, because it would depend on individual tutorial group's experience. Another respondent indicated that in their program the amount of classroom time spent on this content was open to the professor who taught the subject. Having a student choose to complete their senior practicum in palliative care was also cited as a factor that would greatly increase the number of hours a student may spend on content related to death and dying.

Research Question #2 Findings

2. What issues/topics are included as part of the death and dying education provided?

Table 8 lists the specific topics that respondents reported in their school's education about death and dying. This question was answered by 96.5% (28/29) of the respondents. The one respondent who did not answer this question stated that the course on death education was currently being developed. Although no single topic was

addressed by all schools, the most frequently cited topics were: attitudes to death and dying (92.9%, 26/28), communication with dying patients' family and friends (92.9%, 26/28), and exploration of own attitudes to death and dying (92.9%, 26/28). Communication with dying patients, cultural diversity, loss/grief/bereavement, as well as pain and symptom management were also all included by the majority of respondents (89.3%, 25/28). The role of the nurse and spiritual issues were similarly included by 85.7% (25/28) and 82.1% (23/28) of the respondents respectively. Less common topics were: death anxiety (60.7%, 17/28), legal issues (53.6%, 15/28), and body image (50.0%, 14/28). Issues dealing with gender was the least included topic by respondents (25.0%, 7/28).

Nine respondents (9/28, 32.1%) listed additional topics. The additional topics were: palliative care, the meaning of palliation; concepts of meaning, hope and integrity and strategies to achieve these concepts; physiological changes when dying, palliative performance scale, end-of-life decision making and ethical issues, caring for families, physiology of dying, integrated interdisciplinary collaboration, euthanasia/advanced directives, physical care of dying client/family, developmental influences on death and dying, advocacy, aggressive comfort care, family participation, radiotherapy, suicide, assisted suicide, and chemotherapy.

Table 8

Issues/Topics Included in the Schools' Death and Dying Education

Issues/Topics	Frequency (N=28)	Percent	Valid Percent
Attitudes to death and dying	26	89.7	92.9
Communication with dying patients' family and friends	26	89.7	92.9
Exploration of own attitudes to death and dying	26	89.7	92.9
Communication with dying patients	25	86.2	89.3
Cultural diversity	25	86.2	89.3
Loss, grief, bereavement	25	86.2	89.3
Pain, symptom management	25	86.2	89.3
Role of nurse	24	82.8	85.7
Spiritual issues	23	79.3	82.1
Death anxiety	17	58.6	60.7
Legal issues	15	51.7	53.6
Body image	14	48.3	50.0
Gender issues	7	24.1	25.0
Other	9	31.0	32.1

Notes:
(a) One respondent did not answer this question, stating that the course is currently being developed.
(b) 'Other' issues/topics that respondents stated include: palliative care, meaning of palliation, concepts of meaning, hope and integrity and strategies to achieve, physiological changes with dying, palliative performance scale, end-of-life decision making and ethical issues, caring for families, physiology of dying, integrated interdisciplinary collaboration, euthanasia/advanced directives, physical care of dying client/family, developmental influences on death and dying, advocacy, aggressive comfort care, family participation, radiotherapy, suicide, assisted suicide, chemotherapy.

At each school, a total of 4 to 17 (*SD*=2.9) topics were included in their education on death and dying (see Table 9). The average number of topics reported was 11.4 (*Mdn*=12.0, *Mode*=12). Fifteen school representatives (53.6%) cited 12 or more topics. Thirteen school representatives (46.4%) cited less than 12 topics.

Table 9

Number of Issues/Topics Included

Respondents (N=28)

Mean	Mdn	Mode	SD	Min	Max
11.39	12.00	12	2.859	4	17

Table 10 contains the findings of the chi-square and *t* test analyses to illustrate whether there were statistically significant relationships between each topic/issue and eight variables: size of the graduating class, presence of faculty members who specialize in death and dying, the number of these specialist faculty, presence of a center that specializes in death and dying, presence of a clinical practicum, respondents' satisfaction with content, total number of learning methods utilized, and respondents' feeling regarding their students being prepared to care for a dying patient. A total of 112 bivariate analysis tests explored issues/topics included in death and dying education. Only 10 of these 112 bivariate analysis tests resulted in significant results. The variable *total number of teaching/learning methods utilized* produced five statistically significant results, the highest number when exploring issues/topics included in death and dying education. These five issues/topics were: death anxiety, gender issues, legal issues, spiritual issues, and additional issues (other). There was no statistically significant

relationships between all eight variables and the following issues/topics: attitudes to death and dying, body image, communication with dying patients' family and friends, cultural diversity, loss, grief, bereavement, pain, symptom management, and role of the nurse.

Table 10

Exploring Issues/Topics Included in Death and Dying Education (Bivariate Analysis)

Issue/topic #1 – Attitudes to death and dying

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.233	20	0 .818	No
Presence of faculty who specialize	chi-square	0.315	1	0.575	No
Number of faculty who specialize	*t* test	-0.033	26	0.974	No
Presence of a center that specializes	chi-square	0.270	1	0.340	No
Presence of a clinical practicum	chi-square	0.909	1	0.340	No
Satisfaction with content	chi-square	0.376	1	0.540	No
Total number of learning methods utilized	*t* test	-0.925	25	0.364	No
Feel students are prepared	chi-square	1.626	1	0.202	No

Issue/topic #2 – Body image

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.518	20	0.610	No
Presence of faculty who specialize	chi-square	0.622	1	0.430	No
Number of faculty who specialize	*t* test	-0.232	26	0.818	No
Presence of a center that specializes	chi-square	0.297	1	0.586	No
Presence of a clinical practicum	chi-square	2.440	1	0.118	No
Satisfaction with content	chi-square	0.170	1	0.680	No
Total number of learning methods utilized	*t* test	-1.518	25	0.142	No
Feel students are prepared	chi-square	1.269	1	0.260	No

Issue/topic #3 – Communication with dying patients

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.656	20	0.519	No
Presence of faculty who specialize	chi-square	6.048	1	0.014	Yes
Number of faculty who specialize	*t* test	-1.789	26	0.085	No
Presence of a center that specializes	chi-square	0.000	1	1.000	No
Presence of a clinical practicum	chi-square	1.421	1	0.233	No
Satisfaction with content	chi-square	6.406	1	0.011	Yes
Total number of learning methods utilized	*t* test	-1.628	25	0.116	No
Feel students are prepared	chi-square	1.626	1	0.202	No

Issue/topic #4 – Communication with dying patients' family and friends

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.267	20	0.792	No
Presence of faculty who specialize	chi-square	0.191	1	0.662	No
Number of faculty who specialize	*t* test	0.000	26	1.000	No
Presence of a center that specializes	chi-square	0.270	1	0.603	No
Presence of a clinical practicum	chi-square	0.909	1	0.340	No
Satisfaction with content	chi-square	0.227	1	0.634	No
Total number of learning methods utilized	*t* test	-0.861	25	0.397	No
Feel students are prepared	chi-square	1.626	1	0.202	No

Issue/topic #5 – Cultural diversity

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.186	20	0.854	No
Presence of faculty who specialize	chi-square	0.008	1	0.927	No
Number of faculty who specialize	*t* test	0.954	26	0.349	No
Presence of a center that specializes	chi-square	0.060	1	1.000	No
Presence of a clinical practicum	chi-square	1.421	1	0.233	No
Satisfaction with content	chi-square	0.002	1	0.960	No
Total number of learning methods utilized	*t* test	-1.262	25	0.219	No
Feel students are prepared	chi-square	2.591	1	0.107	No

Issue/topic #6 – Death anxiety

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-1.130	20	0.272	No
Presence of faculty who specialize	chi-square	2.798	1	0.094	No
Number of faculty who specialize	*t* test	-0.598	26	0.555	No
Presence of a center that specializes	chi-square	0.077	1	0.782	No
Presence of a clinical practicum	chi-square	0.706	1	0.401	No
Satisfaction with content	chi-square	4.626	1	0.031	Yes
Total number of learning methods utilized	*t* test	-2.539	25	0.018	Yes
Feel students are prepared	chi-square	2.328	1	0.127	No

Issue/topic #7 – Exploration of own attitudes to death and dying

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.222	20	0.827	No
Presence of faculty who specialize	chi-square	0.191	1	0.662	No
Number of faculty who specialize	*t* test	-0.915	26	0.368	No
Presence of a center that specializes	chi-square	4.320	1	0.038	Yes
Presence of a clinical practicum	chi-square	0.909	1	0.340	No
Satisfaction with content	chi-square	0.227	1	0.634	No
Total number of learning methods utilized	*t* test	-0.861	25	0.397	No
Feel students are prepared	chi-square	0.057	1	0.811	No

Issue/topic #8 – Gender issues

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	1.565	20	0.133	No
Presence of faculty who specialize	chi-square	0.207	1	0.649	No
Number of faculty who specialize	*t* test	0.403	26	0.690	No
Presence of a center that specializes	chi-square	2.411	1	0.121	No
Presence of a clinical practicum	chi-square	0.005	1	0.943	No
Satisfaction with content	chi-square	0.287	1	0.592	No
Total number of learning methods utilized	*t* test	-2.296	25	0.030	Yes
Feel students are prepared	chi-square	0.277	1	0.599	No

Issue/topic #9 – Legal issues

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.196	20	0.846	No
Presence of faculty who specialize	chi-square	0.080	1	0.778	No
Number of faculty who specialize	*t* test	0.825	26	0.417	No
Presence of a center that specializes	chi-square	1.187	1	0.276	No
Presence of a clinical practicum	chi-square	1.741	1	0.187	No
Satisfaction with content	chi-square	0.026	1	0.873	No
Total number of learning methods utilized	*t* test	-3.166	25	0.004	Yes
Feel students are prepared	chi-square	2.773	1	0.096	No

Issue/topic #10 – Loss, grief, bereavement

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.466	20	0.646	No
Presence of faculty who specialize	chi-square	1.402	1	0.236	No
Number of faculty who specialize	*t* test	-0.566	26	0.576	No
Presence of a center that specializes	chi-square	0.000	1	1.000	No
Presence of a clinical practicum	chi-square	1.421	1	0.233	No
Satisfaction with content	chi-square	1.539	1	0.215	No
Total number of learning methods utilized	*t* test	-1.628	25	0.116	No
Feel students are prepared	chi-square	1.626	1	0.202	No

Issue/topic #11 – Pain, symptom management

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.849	20	0.406	No
Presence of faculty who specialize	chi-square	1.402	1	0.236	No
Number of faculty who specialize	*t* test	-1.359	26	0.186	No
Presence of a center that specializes	chi-square	1.688	1	0.194	No
Presence of a clinical practicum	chi-square	1.421	1	0.233	No
Satisfaction with content	chi-square	1.539	1	0.215	No
Total number of learning methods utilized	*t* test	-.252	25	0.803	No
Feel students are prepared	chi-square	.768	1	0.381	No

Issue/topic #12 – Role of nurse

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.744	20	0.448	No
Presence of faculty who specialize	chi-square	0.415	1	0.520	No
Number of faculty who specialize	*t* test	1.373	26	0.181	No
Presence of a center that specializes	chi-square	0.147	1	0.702	No
Presence of a clinical practicum	chi-square	1.421	1	0.233	No
Satisfaction with content	chi-square	0.494	1	0.482	No
Total number of learning methods utilized	*t* test	-1.302	25	0.205	No
Feel students are prepared	chi-square	2.591	1	0.107	No

Issue/topic #13 – Spiritual issues

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.861	20	0.399	No
Presence of faculty who specialize	chi-square	5.200	1	0.023	Yes
Number of faculty who specialize	*t* test	-1.415	26	0.169	No
Presence of a center that specializes	chi-square	0.123	1	0.726	No
Presence of a clinical practicum	chi-square	2.584	1	0.108	No
Satisfaction with content	chi-square	3.406	1	0.065	No
Total number of learning methods utilized	*t* test	-3.309	25	0.003	Yes
Feel students are prepared	chi-square	2.591	1	0.107	No

Issue/topic #14 – Other

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	1.925	20	0.069	No
Presence of faculty who specialize	chi-square	1.052	1	0.305	No
Number of faculty who specialize	*t* test	-0.124	26	0.902	No
Presence of a center that specializes	chi-square	0.000	1	1.000	No
Presence of a clinical practicum	chi-square	0.338	1	0.561	No
Satisfaction with content	chi-square	0.934	1	0.334	No
Total number of learning methods utilized	*t* test	-3.868	25	0.001	Yes
Feel students are prepared	chi-square	0.224	1	0.636	No

The 10 statistically significant tests reflected the following key findings about issues/topics.

1. The schools with one or more faculty members who specialized in death and dying more often included the issue/topic *communication with dying patients* in the content of their death education than schools without any specialists in death and dying (100% versus 70%, $\chi 2 = 6.048$, df = 1, p = .014).

2. Respondents who were satisfied with the content of the death education as part of their school's curriculum were from schools/faculties that more often included the issue/topic *communication with dying patients* in their death education compared to those respondents who were not satisfied with the content of death education in their school's curriculum (100% versus 66.7%, $\chi 2 = 6.406$, df = 1, p = .011).

3. Respondents who were satisfied with the content of the death education in their school's curriculum were from schools/faculties that more often included the issue/topic *death anxiety* in their death education than those respondents that were not satisfied with the content of death education in their school's curriculum (76.5% versus 33.3%, $\chi 2 = 4.626$, df = 1, p = .031).

4. The schools with an accessible center specializing in death and dying, palliative care, or end-of-life care more often included the issue/topic *exploration of own attitudes to death and dying* in their content on death education than those schools that did not have such an accessible specialized center (100% versus 77.8%, $\chi 2 = 4.320$, df = 1, p = .038).

5. The schools with one or more faculty members who specialized in death and dying more often included the issue/topic *spiritual issues* in the content of their death

education than schools without specialists in death and dying (94.4% versus 60%, $\chi 2 = 5.200$, df = 1, p = .023).

6. The topic of *death anxiety* was more often found in schools with a higher number of teaching/learning methods in death education than schools with a lower number of teaching/learning methods (6.65 mean methods versus 4.6 mean methods, $t = -2.539$, df = 25, p = .018).

7. The topic of *gender issues* was more often found in schools with a higher number of teaching/learning methods in death education than schools with a lower number of teaching/learning methods (7.43 mean methods versus 5.35 mean methods, $t = -2.296$, df = 25, p = .03).

8. The topic of *legal issues* was more often found in schools with a higher number of teaching/learning methods in death education than schools with a lower number of teaching/learning methods (6.93 mean methods versus 4.58 mean methods, $t = -3.166$, df = 25, p = .004).

9. The topic of *spiritual issues* was more often found in schools with a higher number of teaching/learning methods in death education than schools with a lower number of teaching/learning methods (3.0 mean methods versus 6.4 mean methods, $t = -3.309$, df = 25, p = .003).

10. Topics other than those listed in the questionnaire were more often found in schools with a higher number of instruction/learning methods in death education than schools with a lower number of teaching/learning methods (7.78 mean methods versus 4.94 mean methods, $t = -3.868$, df = 25, p = .001).

Research Question #3 Findings

3. What instruction/teaching and learning strategies are used to provide death and dying education?

The question on strategies was answered by 96.6% (28/29) of the respondents. As before, one of the respondents did not answer this question, stating that the course on death education was currently being developed. Table 11 contains the findings of the instruction/learning strategies that respondents utilized most frequently in their education on death and dying. Lecture was the most common teaching strategy reported (82.1%, 23/28). Small group discussion (78.6%, 22/28) and case studies (67.9%, 19/28) were the next most frequently cited teaching strategies. Audiovisual aids and supervised clinical experience/practicum were both cited by 64.3% (18/28) of the respondents, and reflective journaling by 60.7% (17/28). Less common teaching strategies included context-based learning/problem-based learning (46.4%, 13/28), self-directed activities (46.4%, 13/28), and role-playing (21.4%, 6/28). Only 10.7% (3/28) of the respondents indicated computer-based learning for death education was used at their school, making it the least common teaching strategy.

Four of the respondents shared additional instruction/learning strategies, these were: Preparation of a manual for pain control, poster presentation of relationship between meaning, hope and integrity, participation in rounds discussion during clinical practice experience regarding a client who is palliative, announcements of conferences, certification exam, learning cell, assignment with a palliative care nurse when possible, and personal testimony/talk with a person about bereavement or about suicide. Respondents also described a variety of computer-based activities including: Utilizing online resources, web links, online interactive activities, and online audiovisual

presentations.

Table 11

Instruction/Teaching and Learning Strategies Utilized in the Schools' Death and Dying Education

Teaching Strategy	Frequency (N=28)	Percent	Valid Percent
Lecture	23	79.3	82.1
Small group discussion	22	75.9	78.6
Case studies	19	65.5	67.9
Audiovisual aids	18	62.1	64.3
Supervised clinical experience/practicum	18	62.1	64.3
Reflective journaling	17	58.6	60.7
Context-based learning/ problem-based learning	13	44.8	46.4
Self-directed activities	13	44.8	46.4
Role playing	6	20.7	21.4
Computer-based learning	3	10.3	10.7
Other	4	13.8	14.3

Notes:
(a) One respondent did not answer this question, stating that their course on death and dying is currently being developed.
(b) 'Other' teaching strategies that respondents stated include: preparation of a manual for pain control, poster presentation of relationship between meaning, hope and integrity, participation in rounds discussion during clinical practice experience regarding a client who is palliative, announcements of conferences, certification exam, learning cell, assignment with a palliative care nurse when possible, and personal testimony/talk with a person about bereavement and about suicide within the past 6 months.
(c) Respondents described a variety of computer-based activities including: utilizing online resources, web links, online interactive activities, and online audiovisual presentations.

In total, 2 to 11 different instruction/learning strategies were used at each school (SD=2.2). The average number of instruction/learning methods was 5.9 (median=5.5). Four instruction/learning methods was the mode (21.4%, 6/28), while 50.0% of respondents (14/28) reported a total of five or fewer methods (see Table 12).

Table 12

Number of Instruction/Learning Strategies Utilized

Respondents (N=28)

Mean	Mdn	Mode	SD	Min	Max
5.86	5.50	4	2.189	2	11

Table 13 contains the findings of chi-square and *t* test analyses that illustrate whether there were statistically significant relationships between each instruction/learning strategy and the eight variables: size of the graduating class, presence of faculty members who specialize in death and dying, the number of these specialist faculty, presence of a center that specializes in death and dying, presence of a clinical practicum, respondents' satisfaction with content, total number of issues/topics included, and respondents' feelings regarding their students being prepared to care for a dying patient. A total of 88 bivariate analysis tests which explored instruction/learning methods utilized in death and dying education were conducted. Only 11 of these were found to be significant. The variable *total number of issues/topics included* had four statistically significant tests, the highest number when exploring the instruction/learning methods utilized in death and dying education. These four instruction/learning methods were as follows: CBL/PBL, reflective journaling, self-directed activities, and additional methods

(other). There were no statistically significant relationships among the eight variables and the following instruction/learning methods: audiovisual aids, computer-based learning, lecture, and role playing.

Table 13

Exploring Instruction/Teaching and Learning Strategies Utilized in Death and Dying Education (Bivariate Analysis)

Instruction/learning Method #1 – Audiovisual aids

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.155	20	0.878	No
Presence of faculty who specialize	chi-square	0.124	1	0.724	No
Number of faculty who specialize	*t* test	-0.242	26	0.810	No
Presence of a center that specializes	chi-square	1.985	1	0.159	No
Presence of a clinical practicum	chi-square	0.706	1	0.401	No
Satisfaction with content	chi-square	0.042	1	0.837	No
Total number of issues/topics included	*t* test	-1.759	25	0.091	No
Feel students are prepared	chi-square	1.028	1	0.311	No

Instruction/learning Method #2 – Case studies

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.023	20	0.982	No
Presence of faculty who specialize	chi-square	5.535	1	0.019	Yes
Number of faculty who specialize	*t* test	-2.001	26	0.056	No
Presence of a center that specializes	chi-square	0.750	1	0.386	No
Presence of a clinical practicum	chi-square	0.089	1	0.766	No
Satisfaction with content	chi-square	5.736	1	0.017	Yes
Total number of issues/topics included	*t* test	-1.435	25	0.164	No
Feel students are prepared	chi-square	0.277	1	0.599	No

Instruction/learning Method #3 – Computer-based learning

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-1.102	20	0.284	No

Presence of faculty who specialize	chi-square	0.008	1	0.927	No
Number of faculty who specialize	*t* test	-0.188	26	0.853	No
Presence of a center that specializes	chi-square	1.668	1	0.194	No
Presence of a clinical practicum	chi-square	2.220	1	0.136	No
Satisfaction with content	chi-square	0.002	1	0.960	No
Total number of issues/topics included	*t* test	-1.759	25	0.091	No
Feel students are prepared	chi-square	0.882	1	0.348	No

Instruction/learning Method #4 – Context-based learning/Problem-based learning

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-1.159	20	0.260	No
Presence of faculty who specialize	chi-square	4.368	1	0.037	Yes
Number of faculty who specialize	*t* test	-1.583	26	0.125	No
Presence of a center that specializes	chi-square	0.074	1	0.785	No
Presence of a clinical practicum	chi-square	7.052	1	0.008	Yes
Satisfaction with content	chi-square	3.172	1	0.075	No
Total number of issues/topics included	*t* test	-3.666	25	0.001	Yes
Feel students are prepared	chi-square	2.773	1	0.096	No

Instruction/learning Method #5 - Lecture

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.861	20	0.400	No
Presence of faculty who specialize	chi-square	0.049	1	0.825	No
Number of faculty who specialize	*t* test	0.152	26	0.881	No
Presence of a center that specializes	chi-square	1.964	1	0.161	No
Presence of a clinical practicum	chi-square	0.273	1	0.601	No
Satisfaction with content	chi-square	0.079	1	0.778	No
Total number of issues/topics included	*t* test	-0.430	25	0.671	No
Feel students are prepared	chi-square	0.130	1	0.719	No

Instruction/learning Method #6 – Reflective journaling

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-0.447	20	0.660	No

Presence of faculty who specialize	chi-square	2.798	1	0.094	No
Number of faculty who specialize	*t* test	0.119	26	0.906	No
Presence of a center that specializes	chi-square	0.079	1	0.778	No
Presence of a clinical practicum	chi-square	2.935	1	0.087	No
Satisfaction with content	chi-square	0.208	1	0.648	No
Total number of issues/topics included	*t* test	-2.273	25	0.032	Yes
Feel students are prepared	chi-square	3.519	1	0.061	No

Instruction/learning Method #7 – Role playing

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	1.161	20	0.260	No
Presence of faculty who specialize	chi-square	1.207	1	0.272	No
Number of faculty who specialize	*t* test	-0.283	26	0.779	No
Presence of a center that specializes	chi-square	0.000	1	1.000	No
Presence of a clinical practicum	chi-square	1.535	1	0.215	No
Satisfaction with content	chi-square	0.006	1	0.940	No
Total number of issues/topics included	*t* test	-1.837	25	0.078	No
Feel students are prepared	chi-square	0.130	1	0.719	No

Instruction/learning Method #8 – Self-directed activities

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	1.759	20	0.094	No
Presence of faculty who specialize	chi-square	0.258	1	0.611	No
Number of faculty who specialize	*t* test	-0.350	26	0.729	No
Presence of a center that specializes	chi-square	1.854	1	0.173	No
Presence of a clinical practicum	chi-square	0.142	1	0.706	No
Satisfaction with content	chi-square	1.529	1	0.216	No
Total number of issues/topics included	*t* test	-2.239	25	0.034	Yes
Feel students are prepared	chi-square	0.120	1	0.729	No

Instruction/learning Method #9 – Small group discussion

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	-1.304	20	0.207	No

Presence of faculty who specialize	chi-square	3.187	1	0.074	No
Number of faculty who specialize	*t* test	-2.147	26	0.041	Yes
Presence of a center that specializes	chi-square	0.123	1	0.726	No
Presence of a clinical practicum	chi-square	3.248	1	0.072	No
Satisfaction with content	chi-square	0.816	1	0.366	No
Total number of issues/topics included	*t* test	-0.968	25	0.342	No
Feel students are prepared	chi-square	0.608	1	0.435	No

Instruction/learning Method #10 – Supervised clinical practice

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	0.063	20	0.951	No
Presence of faculty who specialize	chi-square	0.124	1	0.724	No
Number of faculty who specialize	*t* test	-0.486	26	0.631	No
Presence of a center that specializes	chi-square	0.318	1	0.573	No
Presence of a clinical practicum	chi-square	2.935	1	0.087	No
Satisfaction with content	chi-square	0.588	1	0.443	No
Total number of issues/topics included	*t* test	-0.556	25	0.583	No
Feel students are prepared	chi-square	6.378	1	0.012	Yes

Instruction/learning Method #11 - Other

Variable	Test	Value	df	Finding	Significant ($p<.05$)
Size of graduating class	*t* test	1.104	20	0.283	No
Presence of faculty who specialize	chi-square	2.593	1	0.107	No
Number of faculty who specialize	*t* test	0.332	26	0.742	No
Presence of a center that specializes	chi-square	0.587	1	0.444	No
Presence of a clinical practicum	chi-square	4.636	1	0.031	Yes
Satisfaction with content	chi-square	2.503	1	0.114	No
Total number of issues/topics included	*t* test	-3.864	25	0.001	Yes
Feel students are prepared	chi-square	0.882	1	0.348	No

The 11 statistically significant tests reflect the following key findings about instruction/learning methods.

1. The schools with one or more faculty members who specialized in death and dying more often utilized *case studies* as an instruction/learning method than those schools that did not have faculty members who specialized in death and dying (83.3% versus 40%, $\chi 2 = 5.535$, df = 1, p = .019).

2. The school representatives who were satisfied with the content of the death education in their school's curriculum were from schools/faculties which more often utilized *case studies* as an instruction/learning method as compared to schools where the school representatives were not satisfied with the content of death education in their school's curriculum (88.2% versus 44.4%, $\chi 2 = 5.736$, df = 1, p = .017).

3. The schools with one or more faculty members who specialized in death and dying were more likely to utilize *CBL/PBL* as an instruction/learning method than those schools that did not have faculty members who specialized in death and dying (61.1% versus 20%, $\chi 2 = 4.368$, df = 1, p = .037).

4. The schools that offered a clinical practicum focusing on care of the dying more often utilized *CBL/PBL* as an instruction/learning method than those schools that did not offer a clinical practicum focusing on care of the dying (87.5% versus 31.6%, $\chi 2 = 7.052$, df = 1, p = .008).

5. The schools with a larger number of faculty members who specialized in death and dying were more likely to utilize *small group discussion* as an instruction/learning method than those schools with a fewer number of faculty members who specialize in death and dying (1.8 specialists versus 0.3 specialists, $t = -2.147$, df = 26, p = .041).

6. The schools where the representatives believed their students were prepared to care for a dying patient upon graduation more often utilized *supervised clinical*

experience as an instruction/learning method than in those schools where the representative(s) did not believe their students were prepared to care for a dying patient upon graduation (100% versus 45.5%, $\chi 2 = 6.378$, df = 1, p = .012).

7. Those schools that offered a supervised clinical practicum focusing on the care of the dying more often utilized instruction/learning method(s) other than those listed in the questionnaire than schools that did not offer such a clinical practicum (37.5% versus 5.3%, $\chi 2 = 4.636$, df = 1, p = .031).

8. The instruction/learning method of *CBL/PBL* was more often utilized in schools with a higher number of issues/topics in their death education than schools with a lower number of issues/topics (13.1 mean topics versus 9.7 mean topics, $t = -3.666$, df = 25, p = .001).

9. The instruction/learning method of *reflective journaling* was more often utilized in schools with a higher number of issues/topics in their death education than schools with a lower number of issues/topics (12.2 mean topics versus 9.8 mean topics, $t = -2.273$, df = 25, p = .032).

10. The instruction/learning method of *self-directed activities* was more often utilized in schools with a higher number of issues/topics in their death education than schools with a lower number of issues/topics (12.5 mean topics versus 10.2 mean topics, $t = -2.239$, df = 25, p = .034).

11. The instruction/learning method(s) other than those listed in the questionnaire were more often utilized in schools with a higher number of issues/topics in their death education than schools with a lower number of issues/topics (15.5 mean topics versus 10.6 mean topics, $t = -3.864$, df = 25, p = .001).

Research Question #4 Findings

4. How do these findings compare with those of the previously published study (Downe-Wamboldt & Tamlyn, 1997) examining death education provided to Canadian nursing students?

Table 14 summarizes the comparative findings from this study as compared to the findings of the previous study published by Downe-Wamboldt and Tamlyn in 1997. The findings that could be compared are: Whether or not death education is included in the curriculum, curriculum approaches to death education, average number of hours allocated to both classroom and clinical instruction, methods used to formally evaluate student knowledge of the death and dying content, topic areas included, and teaching methods or strategies utilized.

Inclusion of death education. Almost all respondents in both studies indicated education on death and dying was included in their curriculum. More specifically, all respondents of the Downe-Wamboldt and Tamlyn (1997) study (100%) indicated that death education was included in their nursing programs, while all but one respondent (96.6%) from the present study indicated they included death education in their program. In this one case, a course on death and dying was currently being developed.

Curriculum approaches. Integrating the content on death education throughout the curriculum was the curriculum approach reported by 93% of the respondents in the 1997 study, as compared to 57.1% of respondents in the present study. In the current study an additional 28.6% of respondents indicated death education was provided in two approaches simultaneously (integrated throughout the curriculum as well as in a separate course). This option as a curricula approach was not included for respondents in the

Downe-Wamboldt and Tamlyn (1997) study.

Death education was provided as an elective course according to 26% of respondents in the 1997 study, compared to 7.1% in the current study. Having death education in a separate 'required' course was the curriculum approach used by 7% of the respondents in the 1997 study and 7.1% in the current study.

Time allotted to death education. In the Downe-Wamboldt and Tamlyn (1997) study, an average of 24.5 hours was allocated to classroom instruction of death and dying content, compared to 47.6 hours of classroom instruction in the present study. Respondents indicated an average of 36.25 hours for clinical instruction of death and dying content in the 1997 study, compared to 179.2 hours in the present study.

Evaluation of death education. Although the percentage of respondents that used each evaluative method to assess the cognitive and affective domains of student knowledge differed between the Downe-Wamboldt and Tamlyn (1997) and present study, the order of occurrence of each method was the same. Tests (74%) and papers (67%) were the methods reported most frequently to evaluate the cognitive domain of students' knowledge in the 1997 study. Tests and papers were also the methods respondents reported most frequently in the present study, according to 85.7% and 71.4% of respondents, respectively.

Clinical practice and case studies were the methods reported least frequently in both the Downe-Wamboldt and Tamlyn (1997) and present study to evaluate the students' cognitive domain of death and dying knowledge. In the 1997 study, clinical practice was reported by 63% of respondents and case studies by 52% of respondents. In the present study, clinical practice was reported by 66.7% of respondents and case studies

by 57.1%. Discussion (82%) and clinical practice (63%) were the methods that respondents in the 1997 study identified using most frequently to evaluate the affective domain of student knowledge. In the present study, discussion (95.2%) and clinical practice (61.9%) were also the most frequently cited evaluation methods. Measurements of attitude and death anxiety were the least reported methods to evaluate students' knowledge in the affective domain in both the 1997 and present study. Attitude measurement was reported by 26% of respondents in the 1997 study, compared to 28.6% in the present study. The least common evaluation method, measurement of death anxiety, was reported as an evaluation method by 22% of respondents in the 1997 study and 14.3% of respondents in the present study.

Topic areas included. The specific content included in death education differed between the study published in 1997 and the present study. Over 80% of the respondents to the 1997 survey reported including topics of family needs (85%), bereavement (82%), loss/grief (82%), and communication (82%) in their death education. Topics included by over 80% of the respondents in the present study were attitudes to death and dying (92.9%), communication with dying patients' family and friends (92.9%), exploration of own attitudes to death and dying (92.9%), communication with dying patients (89.3%), cultural diversity (89.3%), loss/grief/bereavement (89.3%), pain/symptom management (89.3%), the role of nurse (85.7%), and spiritual issues (82.1%).

Teaching methods and strategies utilized. The three most common teaching strategies were the same for both studies. Respondents in the 1997 study reported utilizing: lectures (70%), case studies (59%), and small group discussions (59%). Respondents in the present study reported utilizing: lecture (82.1%), small group

discussion (78.6%), and case studies (67.9%). However, there was a considerable difference between the 1997 and present study in the reported use of journal writing as a teaching strategy. Journal writing was reported by only 4% of respondents in the 1997 study, compared to 60.7% of respondents in the present study.

Table 14

Comparison of Findings from the Present Study and Study Published in 1997 that Examined Death Education*

Characteristic	1997 Study (a)	Present Study
Number of schools that received the questionnaire.	29	35
Response rate to mail questionnaire.	27/29 = 93.1%	29/35 = 82.9%
Is death education included in the curriculum?	Yes = 100% No = 0%	Yes = 96.6% No = 3.4% Note (a)
Curriculum approach to death education: Integrated throughout curriculum Integrated throughout curriculum and in separate courses Separate 'elective' course(s) only Separate 'required' course(s) only	 93% not an option 26% 7%	 57% 28% 7% 7%
Average number of hours for classroom instruction.	24.50 hours	47.56 hours
Average number of hours for clinical instruction.	36.25 hours	179.17 hours (b)
Teaching strategies used in death education.	Lectures (70%), case studies (59%), small group discussions(59%), audiovisual aids (59%), self-directed activities (44%), role playing (30%), clinical experience (19%),	Lectures (82%), small group discussion (79%), case studies (68%), audiovisual aids (64%), clinical experience (64%), reflective journaling (61%), CBL/PBL (46%), self-directed activities

	journal writing (4%)	(46%), role playing (21%), computer-based learning (11%)
Topics/issues included in death education.	Family needs (85%), bereavement (82%), loss/grief (82%), communication (82%), pain/symptom control (78%), role health professional (78%), spiritual issues (78%), dying with cancer (74%), ethical issues (70%), hospice movement (63%), cultural diversity (63%), death anxiety (63%), dying with AIDS (59%), legal issues (56%), body image (52%), gender issues (41%)	Attitudes to death and dying (93%), communication with dying patients' family and friends (93%), exploration of own attitudes to death and dying (93%), communication with dying patients (89%), cultural diversity (89%), loss, grief, bereavement (89%), pain, symptom management (89%), role of nurse (86%), spiritual issues (82%), death anxiety (61%), legal issues (54%), body image (50%), gender issues (25%)
Methods used to evaluate student knowledge/attitudes:		
cognitive domain - tests	74%	86%
cognitive domain – papers	67%	71%
cognitive domain – clinical practice	63%	67%
cognitive domain – case studies	52%	57%
affective domain – discussions	82%	95%
affective domain – clinical practice	63%	62%
affective domain – attitude measurement	26%	29%
affective domain – death anxiety measurement	22%	14%

* Downe-Wamboldt, B. & Tamlyn, D. (1997). An international survey of death education trends in faculties of nursing and medicine. *Death Studies, 21*, 177-188.

Notes:
(a) The respondent who said death education was not in their curriculum stated that the course on the subject was currently being developed.
(b) Represents the eight respondents that offered a clinical practicum that focused on care of the dying. This includes the respondent that allotted 300 hours, stating that if the student chooses palliative care or hospice in the final level of preceptorship.

Additional Findings

The following section summarizes additional findings that could be gleaned from responses to both close-ended and open-ended questions contained in the questionnaire. Each specific question and a summary of findings for that question are included. Although respondents were asked to include course objectives and outlines, none chose to do so.

Clinical practicum that focused on care of the dying. Twenty-eight respondents (28/29) answered the question that asked whether or not there was a clinical practicum in their programs that focused on the care of the dying (see Table 15). The one respondent who did not answer this question indicated that the course was currently being developed. The majority of respondents (71.4%, 20/28) did not have a clinical practicum that focused on care of the dying. The remaining eight respondents (28.6%, 8/28) stated there was a clinical practicum that focused on the care of the dying. Only one (3.6%, 1/28) respondent indicated that this clinical practicum was required. For the remaining seven respondents (25.0%, 7/28) this clinical practicum was elective. One of the respondents who said the clinical practicum was elective indicated that the reason it was an elective was that there were "too many students and not enough palliative care nurses/clients."

Table 15

Clinical Practicum Focused on Care of the Dying

Description	Frequency (N=28)	Percent	Valid Percent
No clinical practicum	20	69.0	71.4
Required clinical practicum	1	3.4	3.6
Elective clinical practicum	7	24.1	25.0

Time allotted to clinical practicum that focused on care of the dying. Six of the eight respondents who said there was a clinical practicum that focused on care of the dying provided an actual number of practicum hours. For the eight schools that offered a clinical practicum, the number of hours allotted ranged from 25 to 340 (M=179.2, SD=120.7, Mdn=151.0). No specific number of hours was more common than any other, however, three of the six respondents reported between 108 and 182 hours (see Table 16). Multiple modes were noted, specifically: 25, 108, 120, 182, 300, and 340.

Table 16

Time Allotted to Clinical Practicum

Respondents (N=28)

Mean	Mdn	Mode	SD	Min	Max
179.17	151.00	25	120.672	25	340

Note. Multiple modes exist (25, 108, 120, 182, 300, 340). The smallest value is shown.

The respondent who indicated a practicum of 300 hours explained that this was the case when the student chose palliative care or hospice for their final precepted

practicum. Another respondent explained that the actual amount of hours depends on the availability of both students and clients at that stage of life, with this respondent also indicating that they assign dying clients to students.

Evaluating students' knowledge on death and dying content. One respondent did not answer the question on evaluation as their course was currently being developed. Three-quarters (75%, 21/28) of the 28 respondents indicated students are evaluated on their knowledge of death and dying content. The remaining 25% (7/28) of respondents did not evaluate their students as to their death and dying knowledge. One of the respondents, who said they did not evaluate student knowledge on death and dying, further explained that this knowledge was not evaluated separately, but rather, as part of another evaluation.

Methods used to evaluate students' knowledge on death and dying content. Respondents were then asked to indicate which methods, from a list, were utilized to evaluate student knowledge of death and dying content. All 21 of the respondents who indicated that students' knowledge of death and dying content were evaluated answered this question, with one of these respondents indicating that evaluation 'is woven throughout'. One respondent (4.8%, 1/21) stated only the cognitive domain was evaluated. Most (95.2%, 20/21) respondents identified evaluation of both the cognitive and affective domains. None of the respondents indicated their school evaluated only the affective domain.

Tests (85.7%, 18/21) and written papers (71.4%, 15/21) were the methods most often used to evaluate the cognitive domain of students (see Table 17). Evaluation of clinical practice was used by 66.7% (14/21) of respondents. Although over half of the

respondents (57.1%, 12/21) used case studies to measure the cognitive domain, it was the least common evaluation method cited.

Table 17

Methods Used to Evaluate Students' Cognitive Domain

Respondents (N=21)

Method	Frequency	Percent	Valid Percent
Tests	18	62.1	85.7
Written Papers	15	51.7	71.4
Clinical Practice	14	48.3	66.7
Case Studies	12	41.4	57.1

The majority of respondents (95.2%, 20/21) indicated discussion was used to evaluate the affective domain of student knowledge of death and dying (see Table 18). Clinical practice was the second most frequently used method (61.9%, 13/21). Attitude measurement (28.6%, 6/21) and death anxiety measurement (14.3%, 3/21) were the methods cited least frequently. In summary, students' knowledge of death and dying content was most frequently evaluated in the cognitive domain using tests (85.7%, 18/21) and in the affective domain by discussion (95.2%, 20/21).

Table 18

Methods Used to Evaluate Students' Affective Domain

Respondents (N=21)

Method	Frequency	Percent	Valid Percent
Discussion	20	69.0	95.2

Clinical Practice	13	44.8	61.9
Attitude Measurement(s)	6	20.7	28.6
Death Anxiety Measurement	3	10.3	14.3

Questions 12 through to 17 asked respondents their perspectives on a variety of issues related to educating students about death and dying. Although respondents were provided with a list of options to choose from, space was also provided for respondents to share additional information, such as another unlisted option.

Greatest challenges in providing death education to students. Only one respondent did not answer the question about the greatest challenge in providing death education, stating that the course was currently being developed. The majority of respondents (89.3%, 25/28) indicated their school faced challenges in providing death education to their students, while only 10.7% (3/28) of respondents said there were no challenges.

Lack of time in the curriculum was the most frequent challenge reported (53.6%, 15/28). Lack of clinical placement positions was the second most frequently cited challenge according to 28.6% (8/28) of respondents. One respondent indicated that their school had twice the number of students wanting to take the course that deals with death and dying than spaces available. Lack of knowledgeable and experienced instructors/professors was the least frequently cited challenge, with only 21.4% (6/28) of respondents citing this issue as a challenge (see Table 19).

Students themselves, the schools as a whole, and the general culture of society were the three additional challenges respondents listed. It is notable that one respondent

answered that having death education as an elective rather than required course is a challenge in itself, explaining that because theirs was not a required course, a student may choose not to take the elective course. Furthermore, if that student did not deal with death and dying in a clinical experience, he/she may avoid a focus on death and dying altogether. Another respondent acknowledged that the exposure that students get to death and dying is variable; not all students get equal exposure or the opportunity to have multiple experiences.

Table 19

Challenges Educators Faced

Challenge	Frequency (N=28)	Percent	Valid Percent
Lack of Clinical Placement Positions	8	27.6	28.6
Lack of Knowledgeable and Experienced Instructors/Professors	6	20.7	21.4
Lack of Time in the Curriculum	15	51.7	53.6
Other	6	20.7	21.4

Note. Some respondents indicated more than one challenge.

One respondent indicated that students with minimal clinical experience and limited personal experiences with death and dying may have more difficulty conceptualizing issues, thus creating a challenge for the instructor. Having a 'cure-oriented' culture and lack of priority on death education were additional challenges that were cited as impacting on the school's abilities to provide education on death and dying.

Although most of the respondents (68.0%, 17/25) reported only one challenge, 24.0% (6/25) indicated two challenges and 8.0% (2/25) indicated three challenges.

School's view regarding the provision of death education. Respondents were asked to indicate what they believed was their school's view regarding the provision of death education to their students. All 29 respondents answered this question. None of the respondents reported that death education was more suitable at the post-basic level, as compared to the basic undergraduate level. In fact, 93.1% (27/29) felt death and dying education should be provided to all undergraduate nursing students to some extent. Two respondents (6.9%) who did not agree with this statement stated opinions. One respondent stated death and dying education should be "allotted a significant attention in basic education." The other respondent stated this education "must be provided." As such, 100% of respondents indicated death and dying education was important for undergraduate nursing students.

Satisfaction with death and dying content in program. Respondents were asked about their satisfaction with the content of death and dying education provided in their program. The majority of the respondents (64.3%, 18/28) who answered this question indicated they were satisfied with the content of their program. One satisfied respondent commented that they "still only touch the tip of the iceberg" but also acknowledged that they do as well as they can, given the "breadth of content and available time". One respondent did not answer the question regarding personal satisfaction with the content of their program, explaining that they were unable to answer the question because their program was not yet developed. One respondent answered both 'yes and no', explaining that although the scenarios in their program covered "essential content", the ideal

situation would be if "all students were able to have an experience in palliative care".

The remaining respondents (32.1%, 9/28) were not satisfied with the content of their program. Of the nine respondents who were unsatisfied, six provided some explanation as to why they felt this way. These reasons included a desire for not only "more" content but also "further integration of content in all theory and practice courses". The need for "all" students to receive this education was also stated. Having a "course on spirituality and cultural aspects related to death and dying" and the need for "more specialized clinical/palliative placements" was also identified. One respondent who taught the last nursing course in their program answered that students "always complained that they felt unprepared to deal with death and dying".

Satisfaction with methods of teaching death and dying content in program. The question concerning satisfaction regarding the methods of teaching death and dying content was answered by all 29 respondents. Once again, respondents were given the opportunity to explain or elaborate on their responses if they so desired. The vast majority of respondents (89.7%, 26/29) were satisfied with the teaching methods utilized. A satisfied respondent indicated he/she would also like to see a course on "spirituality" offered as an elective. Another satisfied respondent indicated that "distance delivery" was being proposed for the 2004/2005 academic year, while another satisfied respondent included the comment "so far" on their questionnaire.

Three respondents (10.3%, 3/29) indicated they were not satisfied with the teaching methods utilized in their program. One of these unsatisfied respondents elaborated on his/her response by indicating that "time and space place limits on creativity – would like to have more active involvement however many students resist –

feeling overwhelmed by multiple demands of full time study, often part time work and family life". The other two unsatisfied respondents did not explain or elaborate as to why they felt this way.

Graduates' opportunity to care for a dying person during their program. All 29 respondents answered the question regarding whether or not all of the graduates from their program will have an opportunity to care for a dying person during their undergraduate program. Almost half of respondents 44.8% (13/29) felt that their graduates would not have cared for a dying person during their program. None of these respondents elaborated on their answer.

Thirty-one percent (9/29) of respondents felt their graduates would have cared for a dying person during their program although one of these respondents wrote the word "probably" and another respondent wrote the word "most" by their answer. One of the respondents, who also answered yes to this question, stated that some of the students "may not have realized the person was dying if not 'actively' dying on their shift".

Almost 25 percent (24.1%, 7/29) of respondents stated they were unsure if their graduates had cared for a dying person during their program. One of these respondents stated that their students had not yet graduated. The remaining six respondents who were unsure did not elaborate on their answer.

Graduates' preparation to care for a dying patient. Question #17 of the questionnaire asked respondents whether or not they felt that their graduates felt prepared to care for a dying patient. One respondent did not answer this question, stating there were no graduates from their program as of yet. The remaining 28 respondents were divided by responses of yes (28.6%, 8/28), no (39.3%, 11/28), and unsure (32.1%, 9/28).

Eight of the 28 (28.6%) respondents indicated they thought their graduates felt prepared to care for a dying patient. One of these respondents stated "as prepared as any graduate feels (they are always scared they don't know enough)."

Some respondents (39.3%, 11/28), however, stated they did not think their graduates felt prepared to care for a dying patient. One of these respondents commented that feeling prepared to care for a dying patient "takes time" and raised the issue of difficulty in measuring this aspect. Another respondent, who indicated that they did not think their graduates felt prepared to care for a dying patient, indicated that "some" students would feel prepared, specifically those students "who were fortunate enough to get clinical experience."

Approximately one-third of respondents (32.1%, 9/28) were unsure if their graduates felt prepared to care for a dying patient. Two respondents elaborated on their views, stating that feeling prepared to care for a dying patient depends on the students' experience(s) with death. One of these respondents raised the issue that students' own level of maturity plays a role in how prepared they would feel to care for a dying patient.

Additional comments on death and dying education. The final question was open-ended and invited respondents to share any additional information on death and dying education. Out of the 29 respondents who returned a completed questionnaire, 8 provided additional comments in this space. Comments generally focused on either the students or the courses.

One respondent remarked that until students actually experience the death of a client they would expect anxiety. Another respondent commented on the individuality of students, noting that some would "naturally gravitate toward care of dying people" while

others "gravitate toward other patient care areas." Another respondent stated that although it was rare to have students who identify elder or palliative care as an interest, when there was a student who exhibited this interest they were usually "older" and had "personal experience within the family." This respondent commented that their students usually "come with dreams of life saving work in the emergency room or intensive care settings, pediatrics or obstetrics," and "the challenge of trying to kindle interest in 18 and 19 year olds regarding care at the end of life."

Three respondents commented specifically on their programs, one stating how lucky they were that their students "care for people at all stages of life" and have great practice settings where "death is normalized" and "dealt with openly." Another respondent commented that their faculty was "currently looking at revising the program." That individual had sent a suggestion to the curriculum committee to increase content around death and dying. Another respondent was confident that their program was adequate. This respondent had traveled to another country to examine/study their health system and how it compares to the Canadian system, and had also completed a course on palliative care in an additional country

Offering a course dealing with death education and counseling that was based on the *Association for Death Education and Counseling* curriculum at the undergraduate level was another opinion shared by a respondent. Another respondent mentioned the importance of advocacy as a role the nurse has when caring for a dying client, commenting that "willingness to help" would be appreciated by patients and families "a great deal."

Chapter 5

Discussion and Implications of Findings

The discussion in this chapter is divided into five sections. In the first section, the response rate of the study is discussed. The subsequent four sections include a discussion of the findings relative to the study's four research questions. Additional findings are integrated throughout the four sections where relevant. Recommendations and implications for future nursing research, practice, and education are presented in view of the findings for each of the four research questions.

Response Rate

The response rate of 82.9% (29/35) was much higher than the 60% that is deemed sufficient by Polit and Hungler (1991) for most research purposes. Sending out the questionnaire in spring greatly increased the likelihood that it would be completed and returned. In contrast, fall is a busy time in the academic year, with start of classes, a time when questionnaires would less likely be completed and returned. Mailing the questionnaire in the summer or over the Christmas break would have also decreased the likelihood that the most knowledgeable person was available or willing to complete it. Given that the information letter asked for the most knowledgeable person to complete the questionnaire, it is likely that this individual had an interest in the survey and would be more likely to complete and return the questionnaire.

An additional factor that likely increased the response rate was ensuring the questionnaire was a reasonable length and included questions that were clearly worded, easy to read and understand. Seeking factual information, as well as the personal opinion of respondents, while assuring anonymity may have also played a role in the high

response rate. Seeking the opinion of respondents was undertaken to gain their knowledge and experience, and as such demonstrated they were respected and valued. The inclusion of a self-addressed, stamped envelope for questionnaire return also enhanced the possibility of completion and ensured it would be returned to the appropriate person. Reminder letters with a repeat questionnaire also provided respondents another opportunity to complete the survey, which also served to highlight the importance of its completion.

The promise of receiving a summary of the results and the news that all Canadian university nursing programs were being asked to participate may have been two additional factors that contributed to the high response rate. Although the purpose of this study was not to compare or rank the effectiveness of programs, respondents could use this as an opportunity to gain an understanding of how other programs address death education and how they compare with these programs. Although all but one respondent reported that death education was included in their programs, non-responding schools may have no death education in their programs.

Although the response rate was high, the researcher needed to be cautious in choosing statistical tests and in interpreting the findings. For instance, multi-variant analysis was not appropriate given the small N. Also, respondents were expected to be the most knowledgeable individuals on the topic of death education at their school; the perspectives they shared may not be representative of other faculty members at their school.

Research Question #1 Discussion

This survey found education on death and dying was formally included in almost

all Canadian nursing undergraduate programs in the 2003-2004 academic year, suggesting that educators consider it an important element of nursing education. This finding is consistent with the literature, which universally suggests death education is an essential component of nursing education programs (Hurtig & Stewin, 1990; Quint, 1967; Sherman, Matzo, Panke, Grant & Rhome, 2003). The literature has also supported the assertion that death education has a significant beneficial effect on the anxiety levels and attitudes of both the student and professional nurse toward caring for the terminally ill (Caty & Tamlyn, 1984; Coolbeth & Sullivan, 1984; Degner & Gow, 1988b; Frommelt, 1991; Lockard, 1989). Including education on death and dying suggests that educators recognize both the impact that caring for a dying person has on nurses, as well as the positive effect that death education has on dying persons and/or their families. A nurse's ability to provide appropriate care to the dying is thought to largely depend on their orientation toward this role, and their own experience of caring for people through the dying process (Alexander, 1990).

Some respondents noted that their curriculum was becoming increasingly full; the inclusion of death education thus clearly indicates the relevance of death education to nursing. All respondents in this study also shared their belief that undergraduate nursing programs should include death education. No respondent indicated they thought death education was better suited for post-graduate programs or that it was not necessary. Although respondents felt strongly that education on death and dying should be included in nursing undergraduate education, the majority indicated they were challenged by a lack of time in the curriculum and limited clinical placements.

Curricula approach and time allocated to death education. The majority of

respondents in this study stated their schools integrated death education throughout the curricula. Integrating death education throughout the curriculum was also the approach cited by the majority of respondents in previous surveys that examined death education (Caty & Downe-Wamboldt, 1983; Coolican, Stark, Doka & Corr, 1994; Dickincon, Sumner & Durand, 1987, Thrush, Paulus & Thrush, 1979). This practice is in contrast to the views of Benoliel (1988) and Degner and Gow (1988b) that a separate, required course accompanied by clinical experience is the best approach to death education.

However, the findings from this study offer some support for Seidel's (1990) contention that death education should be considered a continuous process. Learning about death and dying cannot be completed in a single, specific course or through one clinical assignment (Seidel). Survey respondents from Caty and Downe-Wamboldt's (1983) study were in almost unanimous agreement that integrating death education throughout the curriculum was the best strategy; this was reflective of the respondents' views that death and dying is a normal stage of the life cycle. Therefore, respondents considered the incorporation of death education content into other courses as the most appropriate curriculum approach (Caty & Downe-Wamboldt).

Yet, Coolican, Stark, Doka, and Corr (1994) argued that by not providing death education as a separate course, educators are demonstrating that they do not consider death education a serious issue. Their view was not supported by the current study. Although the majority of respondents indicated an integrated approach was used in their curricula, these respondents clearly indicated their belief that death education was an important element of nursing education. However, these were the perspectives of the individuals who completed the survey, they are not necessarily reflective of their school

or their profession as a whole.

Respondents in this study cited difficulty in quantifying the amount of death education when it was integrated throughout their curricula. Respondents in the Caty and Downe-Wamboldt (1983) study also cited this same difficulty. This may be the reason why only one third of the respondents in the current study indicated a target number of hours was allotted for death education at their school.

Specialists in EOL/PC. Although this study did not seek information regarding the educational background of the professors who were considered specialists, respondents did indicate whether or not they had "specialists" in their faculty. Although a school may have one or more specialists in PC/EOL on their faculty, with death education integrated throughout their curricula, it is doubtful that these specialists provide all of the death education that is included in the various courses. Instead, a specialist in EOL/PC would likely be a strong advocate for death education, perhaps increasing the time allotted to it or the variety of topics addressed and types of teaching methods utilized. This may explain why the present study found the additional topics of communication with dying patients and spiritual issues, and the teaching methods of case studies and CBL/PBL were more commonly found in schools with EOL/PC specialists as compared to schools without these specialists.

Inclusion of clinical practicum. In 1964, Quint and Strauss stated that the care of the dying was not a carefully planned nursing student experience and that a nursing student may complete school without witnessing a death. The present study indicates these concerns remain valid today. The survey found only 1 in 3 respondents thought all their graduants had cared for a dying person, while 2 in 3 thought their graduants had

either not cared for a dying person or were unsure. Both Quint (1967) and Degner and Gow (1988b), who highlighted the variability in nursing student experiences with care of the dying, argued that death education should take a more systematic approach, and be maximized by a supportive clinical environment. Yet, Caty and Tamlyn (1984) raised concerns regarding the potential detrimental effect of having nursing students care for dying persons before they had an opportunity to examine their own feelings and attitudes, and to acquire the nursing skills required to provide this care. The majority of programs in this survey appeared to integrate death education throughout the curriculum, with students caring for a dying person in any clinical practicum offered throughout their nursing program. Therefore, it is possible that nursing students today may care for a dying person prior to receiving any formal education on death and dying.

Despite 220,000 deaths each year in Canada (Wilson et al., 2001), 28.6% of respondents indicated a lack of clinical placements was the greatest challenge they faced in providing death education to nursing students. Clearly, educators and hospital/care agencies must collaborate to make more opportunities available for nursing students to care for dying persons. Rather than relying on palliative care units in hospitals and long-term-care facilities, educators must be creative in finding clinical placements. Spending time in a loss/bereavement support group, palliative home care visit, a funeral home, or with an organ transplant team are some learning activities that would give students the opportunity to explore concepts related to death and dying (Morgan, 1988).

Several authors assert clinical experience is a necessary element of death education (Benoliel, 1988; Clingerman, 1996; Degner & Gow, 1988b; Johansson & Lally, 1990-91). Despite the fact that a clinical experience was ranked as a top priority

for nursing students by Canadian nursing programs (Downe-Wamboldt & Tamlyn, 1997), the findings from this study indicate this is not the case. In the present study, only one respondent indicated their school had a 'required' clinical practicum for all students that focused on care of the dying. The majority of respondents (71.4%) reported their schools did not offer a clinical practicum. Findings from this study highlighted the variability in student experiences with dying persons, a finding which is consistent with other studies (Quint, 1967; Lloyd-Williams & Field, 2002). Although it is evident that educators recognize the value in students caring for dying patients during their formative nursing education, rarely has this been put into practice.

Recommendations and implications for future nursing research, practice, and education.

1. For schools with minimal death education, these schools could examine the content of courses outside nursing. Other faculties may offer courses that address such topics as aging, bereavement, spirituality; or health care ethics; topics integral to death education. By choosing to make additional nursing, non-nursing, or co-taught courses a requirement in the curriculum, the death education component of the nursing curricula would be increased.

2. All schools should ensure all nursing students have clinical experiences with terminally-ill and/or dying persons. The variety of clinical placements could be increased to ensure this. Time spent in grief support groups, and with clergy or social workers may provide valuable learning experiences.

3. All students should reflect on caring for terminally-ill or dying persons. Students could keep a record of their clinical assignments, with the aim to care for a

terminally-ill dying person at some point each year and to gain through this experience.

4. Nurse educators must continue to advocate for death education, in both classroom and clinical environments, despite an increasingly full curriculum. This advocacy is needed to enhance the capability of nurses in caring for dying persons and their families.

5. Nursing specialists should be used to ensure students receive accurate information and are better guided in developing attitudes and skills. Faculty members who are PC/EOL specialists should be guest speakers/instructors in classrooms and/or post clinical discussion where death education is being addressed. Although these specialists may not be the main course instructor, their expertise should be recognized and brought into the classroom for the benefit of the students.

Research Question #2 Discussion

The survey found that the majority of respondents (64.3%) were satisfied with the content of death education in their programs. The average number of death education topics reported was 11.4, with all respondents reporting a minimum of 4 different death education topics were addressed in their curriculum. Although all respondents reported no single topic, the majority (93%) reported exploring attitudes toward death and dying, exploring one's personal attitude, and communication with dying patients' family and friends. Other authors have similarly reported that the exploration of personal feelings about death has been a vital aspect of death education (Caty & Tamlyn, 1984; Frommelt, 1991; Hurtig & Stewin, 1990; Matzo et al., 2003; Quint, 1967).

The findings of this study suggest that educators universally recognize the importance of communication, as the majority of respondents identified the inclusion of

communication with dying patients as part of their school's death education. This finding is supported by Hjorleifsdottir and Carter's (2000) study, which identified that students were concerned about communicating with dying persons.

In this study, ethical issues, advance directives, and assisted suicide were additional topics that respondents reported were part of their school's death education. Haisfield-Wolfe (1996) also reported that the topics of advance directives and assisted suicide are reflective of current nursing practice regarding providing care to dying persons.

It is also relevant to consider that this study found topics such as death anxiety, gender issues, legal issues, spiritual issues, and other issues were much more likely to be addressed in programs that utilized a higher number of teaching/learning strategies in death education. It would appear that utilizing a large number of teaching/learning methods leads to an increase in the number and variety of topics addressed in death education.

This study also found no statistically significant relationships existed among seven topics and the eight dependent variables examined. This meant seven topics (i.e. attitudes to death and dying, body image, communication with dying patients' family and friends, cultural diversity, loss/grief/bereavement, pain/symptom management, and role of the nurse) were included in the school's death education regardless of the specific program characteristics examined. These findings may illustrate that educators consider certain topics essential elements of death education, and are therefore imperative to address.

Recommendations and implication for future nursing research, practice, and education.

1. As social changes and health care and system changes are certain to affect death and dying, educators need to be prepared to notice and adopt current topics into educational programs.

2. As education is best planned to address student-learning needs, research should be undertaken to assess the needs of nursing students in regard to death and dying. Clinical and/or classroom instructors could also ask students what concerns them most about caring for a dying person. This research should validate educational topics.

3. As it is evident that educators are generally satisfied with the theoretical content but concerned about attitudes and practical skill development, additional learning could be targeted for these concerns. For instance, students may benefit from observing and interviewing nurses who care for dying persons in a variety of settings. This exposure may be very important for some students who find death and dying especially challenging.

Research Question #3 Discussion

In this study, the majority of respondents (89.7%) were satisfied with the teaching methods utilized. The average number of methods utilized was 5.9, with all respondents citing at least 2 methods. In this study, lecture was found to be the most common teaching strategy; however, it was never the only strategy cited. Respondents in this study indicated a range of 2 to 11 teaching methods were used for education on death and dying. This finding of a multi-method approach is consistent with the literature. Lecture alone has been considered ineffective for death education; particularly when exploring

the topics of loss, grief, and bereavement (Matzo et al., 2003).

It is also relevant to note that Clingerman (1996) and Morgan (1988) both identified journaling as an effective teaching/learning tool. Reflective journaling was cited by 60.7% of respondents in this study, suggesting that the majority of educators in Canada consider it an effective teaching/learning strategy. Morgan also found that although examinations and research papers were included in a course on death, dying, and bereavement; the personal journal was considered the most important assignment, as it integrated lectures, reading, and personal experiences.

Almost half of the respondents in this study cited the use of CBL/PBL in death education. This finding is consistent with the findings of a study by Mok, Lee, and Wong (2002). They reported the use of CBL/PBL to explore death and dying was very effective, hence, strongly recommended. Mok, Lee, and Wong found the students considered CBL/PBL tutorials a safe environment for discussion, including the sharing of feelings and information. The CBL/PBL learning experience may thus provide students the opportunity to develop self-awareness in a safe group environment. CBL/PBL is also credited with helping students develop lifelong learning skills, as they are engaged in self-directed learning (Alexander, McDanial, Baldwin & Money, 2002; Biley, 1999). These elements of the CBL/PBL learning experience may create a learning atmosphere that is very conducive to exploring death and dying. However, CBL/PBL may also increase variability in the depth and the amount of time students spend on the subject, as student learning occurs in separate small groups and not always in the presence of a professor/instructor.

Having a palliative care nurse serve as a preceptor to a student was an additional

teaching strategy cited by some respondents in this study. This particular teaching strategy has already been mentioned in the literature as being particularly effective in regard to death education (Birkholz, Clements, Cox & Gaume, 2004).

In this study, a larger number of topics were linked with the following teaching/learning strategies: CBL/PBL, reflective journaling, self-directed activities, and additional methods not specifically surveyed in the questionnaire. This may indicate that the large number of topics regarding death education require a variety of teaching/learning strategies.

Recommendations and implication for future nursing research, practice, and education.

1. With reflective journaling considered effective in enhancing student learning of death education and other personally sensitive topics, schools are encouraged to adopt reflective journaling and to test its effectiveness.

2. Course evaluations, in general, are needed to examine the effectiveness of teaching strategies utilized. Studies are also needed to seek student input/feedback regarding teaching methods and topics.

3. As some students may have a high level of death anxiety, and therefore require additional information and support, these students should be identified. Such students may have a difficult time participating in classroom activities regarding death education or avoid clinical environments where patients die. These students will need additional support and learning opportunities.

4. Educators have been creative in regard to teaching strategies. Educators or schools with less creativity should be encouraged to be more creative as this appears key

to addressing a larger number of death and dying topics.

Research Question #4 Discussion

The findings of this survey are similar to those of the 1997 Canadian survey by Downe-Wamboldt and Tamlyn (1997) with the following four exceptions.

Average number of hours allocated to both classroom and clinical instruction. The present study findings versus the Downe-Wamboldt and Tamlyn (1997) study findings suggests there has been an increase in time allotted to both classroom and clinical instruction of death education. This increase could be a reflection of educators increasingly recognizing the significance of death and dying education. The respondents did, however, note variability in student clinical experiences. Some respondents indicated that more students wanted to obtain positions in clinical practicums that focused on care of the dying than were available. As only 5% of dying people receive specialized palliative care (Subcommittee of the Senate, 2000), their comments are reflective of the difficulty in arranging clinical experience in a palliative care unit or hospice.

Methods used to formally evaluate students' knowledge of the death and dying content. The order of frequency with regards to the methods used to evaluate student knowledge and attitudes were the same in both the 1997 and current study. Methods that varied the most from 1997 to 2003-04 were discussions (affective domain, which increased by 13%), and tests (cognitive domain, which increased by 12%). These findings offer support to the use of discussion as an effective method for exploring the emotional state and personal growth of students (Mok, Lee, & Wong, 2002). The increase in tests may be explained by the fact that death education is integrated throughout the curriculum in most schools now.

Topic areas included. It is difficult to compare the findings from the present study to those of Downe-Wamboldt and Tamlyn's (1997) study since the survey tools used in each study did not list the same topics for selection by respondents. With schools continually updating their curricula, it is understandable that this list would change over time. However, two topics were consistently and predominantly addressed. Death anxiety and spiritual issues were topics cited by 63% and 78% of respondents in the 1997 study, and by 61% and 82% of respondents in the current study. Two additional topics, attitudes to death and dying, and exploration of own attitudes to death and dying, were most frequently cited by respondents in the present study, suggesting that respondents in the present study considered these topics fundamental in death education. These two topics (attitudes to death and dying, and exploration of own attitudes to death and dying) were not listed for selection in the 1997 survey, which could indicate that they are either new topics or old topics that were missed in the previous study.

Teaching methods and strategies utilized. Although the four teaching strategies most frequently used for death education were found to be the same in both studies, their order of frequency differed. The main difference in teaching strategies was the use of journal writing. In the 1997 study, journal writing was cited as in use by only 4% of respondents, whereas 61% of respondents in the present study cited it was in use. Educators may be more receptive now to its use because they acknowledge its benefits in exploring student perceptions of death and dying and/or are increasingly comfortable using it as a teaching/learning tool.

Recommendations and implication for future nursing research, practice, and education.

1. Provide educators the opportunity to reflect on the current status of death education in their programs and make changes as needed or desired. Continue to survey nursing schools every three to five years regarding death education, including the challenges they face in making it personally relevant, in-depth, and accessible.

2. Networking could provide educators with valuable information, creative insight, and collegial support. EOL conferences for nurse educators so they could meet and discuss issues regarding death education with colleagues may be particularly helpful.

3. Design and participate in research studies that identify the education that is most effective at increasing nurse comfort and abilities in caring for the dying. This evidence could guide curriculum development in classroom and clinical practicums.

4. Survey new graduates upon graduation and one year later regarding their knowledge, attitudes, comfort with talking, and comfort providing care to the dying. This comparative survey may provide valuable information to improve death education.

5. Examine the effectiveness of nurses in providing EOL care. Individuals and family members who have received their care may be particularly relevant to involve in such studies.

6. Increase the number and availability of EOL courses for post-RNs and graduate students. This should increase the number of educators and preceptors with more knowledge in EOL care.

In summary, this chapter includes a discussion of the findings for each of this study's four research questions. This chapter also included a discussion of the results from the survey questions that asked respondents' perspectives regarding death education. This information was integrated throughout this chapter. Although these

respondents' perspectives may not be representative of the schools, they provide additional insights. Recommendations and implications for future nursing research, practice, and education were also presented in this chapter. These recommendations and implications for future nursing research, practice, and education were based on the findings for each of the four research questions.

Chapter 6

Summary and Conclusion

This study was undertaken to explore and describe the extent of death education in Canadian undergraduate baccalaureate nursing programs during the 2003-2004 academic year. Information from an early 2004 mail survey of nursing schools/faculties was used to answer four research questions. The 82.9% response rate raises confidence in the results of this survey. Almost all respondents indicated death education was already included in their undergraduate nursing curricula, with one respondent indicating death education would be included in the following year. It should be noted that there were non-responders, and their schools might not include death education in their programs. Nevertheless, the findings indicate Canadian nursing educators generally recognize the importance of death education.

The findings of this study also illustrate that although death education is a common curricula component, there is great variety in the extent and depth of this content. Death education was most often integrated throughout the curriculum rather than concentrated in a separate course through a combination of courses, CBL/PBL tutorials, and clinical experiences. Furthermore, a clinical practicum that focused exclusively on the care of the dying was rarely offered. Lack of time in the curricula and lack of clinical placements were the two main challenges that respondents reported.

A general description of death education was acquired, including specific content and the teaching methods used. Although no single topic was included by all respondents, almost 90% reported the following seven topics: Attitudes to death and dying, communication with dying patients' family and friends, exploration of own attitudes to

death and dying, communication with dying patients, cultural diversity, loss/grief/bereavement, and pain/symptom management. Respondents indicated an average of 11.4 topics were addressed in relation to death education. Instruction/learning methods varied considerably, and ranged in total from 2 to 11. Lecture, the most common method, was reported by 82% of respondents. The next most common teaching methods utilized were small group discussion and case studies, reported by 78.6% and 67.9% of respondents respectively. Compared to Downe-Wamboldt and Tamlyn's (1997) study, more time is now allotted to death education both in the classroom and clinical areas. An increase in the use of tests and discussions to evaluate student knowledge/attitudes, including reflective journaling, was also noted.

All but one respondent reported that death education was included in their program. The one respondent who indicated that their school did not include death education also reported that their school was currently developing a course on the subject.

Perspectives shared by respondents suggest that although all programs either now or will very soon include death education; only one-third believed that their students would have cared for a dying person during these formative undergraduate years. Furthermore, only one-quarter of respondents believed their students felt prepared to care for a dying person upon graduation. These insights are concerning. It could be that most nurses believe that it is difficult to care for dying persons and so students cannot be prepared enough. However, educators are obligated to review and enhance the education provided. If there is concern about the preparation of students, this should be addressed.

Furthermore, although educators were surveyed in this study, students were not. Exploring nursing student views regarding their death education may be needed for

ongoing developments in death education. Post-graduation surveys of new graduates, to explore their comfort, knowledge, and skills in caring for dying persons early in their careers, would permit educators to critically examine and refine death education content in the undergraduate nursing program.

Given that the health care system and post-secondary education system will continue to evolve, these and other death education surveys should be undertaken periodically. One reason for ongoing surveys is to ensure that the care of dying persons is not lost in an increasingly expanding nursing curriculum. The changing role of the nurse will also challenge, as well as guide, educators in their planning. Research that enhances the understanding of the role of the palliative care nurse, as well as points to the knowledge and skills needed by new graduates to care for dying persons and their families, would be extremely valuable for educators in refining their death education.

In conclusion, it is relevant to reflect that dying persons and their families will often require supportive care from nurses. Nurses must be prepared to care for dying persons throughout their career, regardless of where they practice. Educators appear to have recognized this learning need, as nursing schools across Canada have, or will shortly have, death education as a universal component. Considerable variability in death education topics, teaching/learning methods, and clinical experiences are concerns that remain. These concerns are not insurmountable, as researcher and educator activities could readily be undertaken to ensure that all nursing students feel prepared to offer safe and effective care to dying persons and their families.

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Appendix A

Death Education Questionnaire # ___

Title of Study: **An Examination of the Death Education Provided in Canadian Nursing Degree Programs**

Please answer the following questions about your school's baccalaureate nursing degree program. If your school offers a post-RN nursing degree, answer the questions as they relate to the generic baccalaureate nursing degree only. If needed, please pass this survey to the person (or persons) in your faculty whom you feel is/are the most knowledgeable about the death and dying education provided to students in your program or work together to complete it.

Background Information

1. How many students graduated from your undergraduate baccalaureate nursing degree program last year (do not include post-RN graduants)? _____

2. Do you have faculty/school members who specialize or focus their practice on death and dying, palliative care, or end-of-life care?

____ no

____ yes If yes, how many people? _____

3. Is there a center that focuses on death and dying, palliative care, or end-of-life care at your university or in your province?

____ no

____ yes

4. What is your primary position? (if more than one person contributed to this survey, check all that apply)

____ administration (Dean, Director, assistant Dean, undergraduate Dean, Chair)

____ curriculum committee

____ Instructor/Professor

____ other (please explain): _____

Death and Dying Education Questionnaire

There are 18 questions in this questionnaire.

1. Is death and dying education included in the content of your undergraduate baccalaureate nursing degree program?

____ yes

____ no (if no, please go to question 12)

2. If yes, how is the content on death and dying presented? (check only one of the following)

_____ in one or more course(s) that focus only on death education

_____ integrated throughout the curriculum

_____ in separate course(s) and integrated throughout the curriculum

_____ none of the above (please explain):_____

3. If the content on death and dying is the focus in one or more separate course(s), are these:

_____ elective courses, or

_____ required courses

_____ both

4. Is there a specific program year in which most of the content on death and dying is presented?

_____ no

_____ yes If yes, which year? 1st _____, 2nd _____, 3rd _____, 4th _____

5. Is there a target number of hours designated for death and dying classroom instruction?

_____ no, or not applicable (please explain):_____

_____ yes If yes, what is it? _____

6. Which of the following topics are included in the death and dying education for undergraduate students in your program? (check all that apply)

_____ attitudes to death and dying
_____ body image
_____ communication with dying patients
_____ communication with dying patients' families, friends
_____ cultural diversity
_____ death anxiety
_____ exploration of own attitude to death and dying
_____ gender issues
_____ legal issues
_____ loss, grief, bereavement
_____ pain, symptom management
_____ role of nurse
_____ spiritual issues
_____ other (please identify): _____

7. Which of the following teaching methods and strategies are used for the death and dying content? (check all that apply)

_____ audiovisual aids
_____ case studies
_____ computer-based learning
_____ context-based learning/problem-based learning
_____ lecture
_____ reflective journaling
_____ role playing
_____ self-directed activities
_____ small group discussion
_____ supervised clinical experience/practicum
_____ other (please identify): _____

8. Is there a clinical practicum that focuses on care of the dying?

_____ yes, it is a required practicum for all students

_____ yes, but it is elective, not all students take this practicum

_____ no (if no, please go to question 10)

9. How many hours are allotted to the clinical practicum that focuses on care of the dying?_____

10. Are students evaluated on their death and dying knowledge?

_____ yes

_____ no (if no, please go to question 12)

11. Please indicate the method(s) used to evaluate the students' knowledge of death and dying content.

A. Cognitive domain

_____ tests

_____ written papers

_____ clinical practice

_____ case studies

B. Affective domain

_____ discussion(s)

_____ clinical practice

_____ attitude measurement(s)

_____ death anxiety measurement(s)

12. What are the greatest challenges in providing death education to your students?

____ none, no challenges

____ lack of clinical placement positions

____ lack of knowledgeable and experienced instructors/professors

____ lack of time in the curriculum

____ other (please identify):_____

13. Please mark the answer that best reflects your school's view:

_____ death and dying education should be provided (to some extent) to all undergraduate nursing students

_____ death and dying education is more suitable at a post basic level (after students have completed their basic nursing education)

_____ other (please explain):_____

14. Are you satisfied with the content on death and dying that your program provides to students?

_____ yes

_____ no

If no, please explain: _____

15. Are you satisfied with the methods of teaching death and dying content that your program provides to students?

_____ yes

_____ no

If no, please explain: _____

16. At the time of graduation, do you think all your graduates will have cared for a dying person during their undergraduate program?

_____ yes

_____ no

_____ unsure

17. Do you think your graduates feel prepared to care for a dying patient?

_____ yes

_____ no

_____ unsure

18. What additional information on death education would you like to share?

Thank you for participating in this study. Please include death education curriculum/course objectives if you wish. Responses are confidential and anonymous. You will receive a summary of the findings.
Barbara Goodwin, Researcher

_____

Appendix D

Thirty-Five Canadian Undergraduate Baccalaureate Nursing Programs

British Columbia Institute of Technology – Health Sciences (Burnaby, British Columbia)

Trinity Western University – Department of Nursing (Langley, British Columbia)

University of British Columbia – School of Nursing (Vancouver, British Columbia)

University of Northern British Columbia – Nursing Programs (Prince George, British Columbia)

University of Victoria – School of Nursing (Victoria, British Columbia)

Mount Royal College – Undergraduate Nursing Studies (Calgary, Alberta)

University of Calgary – Faculty of Nursing (Calgary, Alberta)

University of Alberta – Faculty of Nursing (Edmonton, Alberta)

University of Lethbridge – School of Health Studies (Lethbridge, Alberta)

University of Saskatchewan – College of Nursing (Saskatoon, Saskatchewan)

University of Manitoba – Faculty of Nursing (Winnipeg, Manitoba)

Brock University – Department of Nursing (St. Catharines, Ontario)

Lakehead University – School of Nursing (Thunder Bay, Ontario)

Laurentian University – School of Nursing (Sudbury, Ontario)

Nipissing University – Nursing Department (North Bay, Ontario)

McMaster University – School of Nursing (Hamilton, Ontario)

Queen's University – School of Nursing (Kingston, Ontario)

Trent University – Nursing Program (Peterborough, Ontario)

University of Ontario Institute of Technology – School of Health and Human Studies (Oshawa, Ontario)

Ryerson University – School of Nursing (Toronto, Ontario)

University of Toronto – Faculty of Nursing (Toronto, Ontario)

University of Ottawa – School of Nursing (Ottawa, Ontario)

University of Western Ontario – School of Nursing (London, Ontario)

University of Windsor – School of Nursing (Windsor, Ontario)

York University – School of Nursing (North York, Ontario)

Universite Laval – Faculte des sciences infirmieres (Quebec City, Quebec)*

McGill University – School of Nursing (Montreal, Quebec)

Universite de Montreal – Faculte des sciences infirmieres (Montreal, Quebec)*

Universite du Quebec en Outaouais – Dept. des sciences de la sante (Gatineau, Quebec)*

Universite de Moncton – Ecole des sciences infirmieres (Moncton, New Brunswick)*

University of New Brunswick – Faculty of Nursing (Fredericton, New Brunswick)

Dalhousie University – School of Nursing (Halifax, Nova Scotia)

St. Francis Xavier University – School of Nursing (Antigonish, Nova Scotia)

University of Prince Edward Island – School of Nursing (Charlottetown, PEI)

Memorial University of Newfoundland – School of Nursing (St. John's, Newfoundland)

* French questionnaire sent to these schools.

Appendix E

Collaborative Baccalaureate Partnerships

British Columbia Institute of Technology – Health Sciences (Burnaby, British Columbia)

Trinity Western University – Department of Nursing (Langley, British Columbia)

University of British Columbia – School of Nursing (Vancouver, British Columbia)

University of Northern British Columbia – Nursing Programs (Prince George, British Columbia)

Partners with: College of New Caledonia

University of Victoria – School of Nursing (Victoria, British Columbia)

Partners with: Camosun College, North Island College, Douglas College, Okanagan University College, Selkirk College, University-College of the Caribou, Malaspina University-College, Kwantlen University College, Langara College

Mount Royal College – Undergraduate Nursing Studies (Calgary, Alberta)

Partners with: Athabasca University

University of Calgary – Faculty of Nursing (Calgary, Alberta)

Partners with: Medicine Hat College, Mount Royal College

University of Alberta – Faculty of Nursing (Edmonton, Alberta)

Partners with: Keyano College, Red Deer College, Grant MacEwan Community College, Grande Prairie Regional College

University of Lethbridge – School of Health Studies (Lethbridge, Alberta)

Partners with: Lethbridge Community College

University of Saskatchewan – College of Nursing (Saskatoon, Saskatchewan)

Partners with: Saskatchewan Institute of Applied Science & Technology

University of Manitoba – Faculty of Nursing (Winnipeg, Manitoba)

Partners with: Red River Community College, Keewatin Commuity College

Brock University – Department of Nursing (St. Catharines, Ontario)

Partners with: Loyalist College

Lakehead University – School of Nursing (Thunder Bay, Ontario)

Partners with: Confederation College

Laurentian University – School of Nursing (Sudbury, Ontario)

Partners with: Cambrian College, College Boreal, Northern College, Sault College

Nipissing University – Nursing Department (North Bay, Ontario)

Partners with: Canadore College

McMaster University – School of Nursing (Hamilton, Ontario)

Partners with: Conestoga College, Mohawk College

Queen's University – School of Nursing (Kingston, Ontario)

Partners with: St. Lawrence College

Trent University – Nursing Program (Peterborough, Ontario)

Partners with: Sir Sanford Fleming

University of Ontario Institute of Technology – School of Health and Human Studies (Oshawa, Ontario)

Partners with: Durham College

Ryerson University – School of Nursing (Toronto, Ontario)

Partners with: Centennial College, George Brown College

University of Toronto – Faculty of Nursing (Toronto, Ontario)

University of Ottawa – School of Nursing (Ottawa, Ontario)

Partners with: Algonquin College, La Cite Collegiale

University of Western Ontario – School of Nursing (London, Ontario)

Partners with: Fanshawe College

University of Windsor – School of Nursing (Windsor, Ontario)

Partners with: Lambton College, St. Clair College

York University – School of Nursing (North York, Ontario)

Partners with: Georgian College, Seneca College, Durham College

Universite Laval – Faculte des sciences infirmieres (Quebec City, Quebec)

McGill University – School of Nursing (Montreal, Quebec)

Universite de Montreal – Faculte des sciences infirmieres (Montreal, Quebec)

Universite du Quebec en Outaouais – Dept. des sciences de la sante (Gatineau, Quebec)

Members of associated group: Chicoutimi, Rimouski, Trois Rivieres

Universite de Moncton – Ecole des sciences infirmieres (Moncton, New Brunswick)

University of New Brunswick – Faculty of Nursing (Fredericton, New Brunswick)

Partners with: Humber College

Dalhousie University – School of Nursing (Halifax, Nova Scotia)

Partners with: Nunavut Arctic College

St. Francis Xavier University – School of Nursing (Antigonish, Nova Scotia)

Partners with: University College of Cape Breton

University of Prince Edward Island – School of Nursing (Charlottetown, PEI)

Memorial University of Newfoundland – School of Nursing (St. John's, Newfoundland)

Partners with: Centre for Nursing Studies, Western Health Care Corporation

Appendix G

Budget

General Supplies and Services

Large envelopes – introductory letter, questionnaire (35 X $0.21 + GST)....$ 7.86

Large envelopes – reminder letter, questionnaire, introductory letter

(26 X $0.21 +GST).....$ 5.84

Small envelopes – questionnaire return (35 X $0.05).....$ 1.75

Small envelopes – reminder letter questionnaire return (26 X $0.05).....$ 1.30

Photocopying – questionnaire, introductory letter

(35 X 7 pages X $.11 + GST).....$ 28.84

Photocopying – reminder letter, questionnaire, introductory letter

(26 X 8 pages X $.11 + GST).....$ 24.48

Photocopying – dissemination of findings (29 X 10 pages X $.11 + GST)..$ 34.13

Stamps - mailing questionnaire, introductory letter

($.98 X 35 + GST).....$ 36.70

Stamps - questionnaire return ($.49 X 35 + GST).....$18.35

Stamps - mailing reminder letter package ($.98 X 26 + GST).....$ 27.26

Stamps - questionnaire return in reminder letters ($.49 X 26 + GST).....$13.63

Stamps - dissemination of findings ($.98 X 29 + GST).....$ 30.41

French Translation of Documents.....$ 403.58

TOTAL.....$ 634.13